MEDDD

WAR DEPARTMENT
Office of The Surgeon General
Washington 25, D. C.

U. S. Surgeon-General's office

18 October 1946

MEMORANDUM FOR

Subject: Report of Conference of The Surgeon General with Commanders of Named General Hospitals

1. There is transmitted herewith for your information a copy of the report of the conference of The Surgeon General with commanders of named general hospitals on 22 - 23 August 1946, at The Pentagon, Washington, D. C.

FOR THE SURGEON GENERAL:

Guy B. Denit

1 Incl.
Report of Conference

GUY B. DENIT
Brigadier General, USA
Chief of Plans and Operations

DISTRIBUTION:

2 copies, each, to commanders of named general hospitals A,B,C.

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CONFERENCE OF THE SURGEON GENERAL
with
COMMANDERS OF NAMED GENERAL HOSPITALS
Washington, D. C.

22 - 23 August 1946

I N D E X

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WITH
COMMANDERS OF GENERAL HOSPITALS
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CONFERENCE OF THE SURGEON GENERAL
with
COMMANDERS OF NAMED GENERAL HOSPITALS
Washington 25, D. C.

22 - 23 August 1946

The conference of The Surgeon General with commanders of named general hospitals was convened at 0900 hours, 22 August 1946, Room 2E 408, The Pentagon, Washington, D. C. The following were present:

Office of The Surgeon General

Major General Norman T. Kirk, USA
The Surgeon General

Brigadier General Raymond W. Bliss, USA
Deputy Surgeon General

Brigadier General Guy B. Denit, USA
Chief of Plans and Operations

Commanders of Named General Hospitals

Brigadier General George C. Beach, USA
Walter Reed General Hospital
Washington, D. C.

Brigadier General Charles C. Hillman, USA
Letterman General Hospital
San Francisco, California

Brigadier General Omar H. Quade, USA
Fitzsimons General Hospital
Denver, Colorado

Colonel Clyde M. Beck, MC
Pratt General Hospital
Coral Gables, Fla.

Colonel C. K. Berle, MC
O'Reilly General Hospital
Springfield, Missouri

CONFERENCE OF THE SURGEON GENERAL
WITH
COMMANDERS OF NAMED GENERAL HOSPITALS
Washington 25, D. C.

22 - 23 August 1956

The conference of The Surgeon General with commanders of named general hospitals convened at 0900 hours, 22 August 1956, Room 2E 608, The Pentagon, Washington, D. C. The following were present:

Office of The Surgeon General

Major General S. B. Hays, USA
The Surgeon General

Brigadier General Raymond W. Bliss, USA
Deputy Surgeon General

Brigadier General Guy B. Denit, USA
Chief of Plans and Operations

Commanders of Named General Hospitals

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Colonel Clyde M. Beck, MC
Pratt General Hospital
Coral Gables, Fla.

Colonel C. L. [illegible], MC
O'Reilly General Hospital
Springfield, Missouri

Colonel Paul Crawford, MC
Wakeman General Hospital
Cp. Atterbury, Indiana

Colonel Cleon J. Gentzkow, MC
Valley Forge General Hospital
Phoenixville, Pa.

Colonel John R. Hall, MC
Bruns General Hospital
Santa Fe, New Mexico

Colonel Robert M. Hardaway, MC
Bushnell General Hospital
Brigham City, Utah

Colonel Maxwell G. Keeler, MC
Madigan General Hospital
Tacoma, Washington

Colonel Paul A. Keeney, MC
Murphy General Hospital
Waltham, Mass.

Colonel Floyd V. Kilgore, MC
Cushing General Hospital
Framingham, Mass.

Colonel Henry L. Krafft, MC
Mayo General Hospital
Galesburg, Ill.

*Colonel Asa Lehman, MC
Army & Navy General Hospital
Hot Springs, Ark.

Colonel Hew B. McMurdo, MC
Oliver General Hospital
Augusta, Ga.

Colonel Carl R. Mitchell, MC
McCornack General Hospital
Pasadena, Calif.

**Colonel Roary A. Murchison, USA
Percy Jones General Hospital
Battle Creek, Michigan

* To replace Colonel Upshur as Commanding Officer, Army & Navy General Hospital.
** Representing Commanding General, Percy Jones General Hospital.

Colonel Paul Crawford, MC
Wakeman General Hospital
Camp Atterbury, Indiana

Colonel Glenn [illegible], MC
Valley Forge General Hospital
Phoenixville, Pa.

Colonel John R. Hall, MC
Bruns General Hospital
Santa Fe, New Mexico

Colonel Robert M. Hardaway, MC
Bushnell General Hospital
Brigham City, Utah

Colonel Maxwell G. Keeler, MC
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Colonel Paul A. Keeney, MC
Murphy General Hospital
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Colonel Floyd V. [illegible], MC
Cushing General Hospital
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Colonel Harry L. [illegible], MC
Mayo General Hospital
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*Colonel Leo [illegible], MC
Army & Navy General Hospital
Hot Springs, Ark.

Colonel Ray E. [illegible], MC
Oliver General Hospital
Augusta, Ga.

Colonel Roy E. Mitchell, MC
McCornack General Hospital
Pasadena, Calif.

**Colonel Henry A. Murchison, MC
Percy Jones General Hospital
Battle Creek, Michigan

* To replace Colonel Upshur as Commanding Officer, Army & Navy General Hospital.
** Representing Commanding General, Percy Jones General Hospital.

Colonel Cleve C. Odom, MC
Mason General Hospital
Brentwood, LI, New York

Colonel Charles A. Pfeffer, MC
Old Farms Convalescent Hospital
Avon, Conn.

Colonel George W. Reyer, MC
Wm. Beaumont General Hospital
El Paso, Texas

Colonel Edwin H. Roberts, MC
Murphy General Hospital
Waltham, Mass.

Colonel Oramel J. Stanley, MC
Halloran General Hospital
Willowbrook, LI, New York

Colonel Paul H. Streit, MC
Brooke General Hospital
Ft. Sam Houston, Texas

Colonel Samuel J. Turnbull, MC
Tilton General Hospital
Ft. Dix, N. J.

Colonel Alfred E. Upshur, MC
Army & Navy General Hospital
Hot Springs, Ark.

Colonel Dean F. Winn, MC
Moore General Hospital
Swannanoa, N. C.

A. WELCOMING ADDRESS.....Major General Norman T. Kirk

STATEMENT OF CONFERENCE AIMS.....Brigadier General Raymond W. Bliss

Major General Norman T. Kirk, The Surgeon General, opened the conference at 0900 hours, 22 August 1946 with a welcoming address to the hospital commanders. He then called upon Brigadier General Raymond W. Bliss, The Deputy Surgeon General to set forth the conference aims. General Bliss extended his greetings to the hospital commanders, and set forth the conference aims in the following statements:

This conference of hospital commanders is the first held since certain Army medical facilities were designated as Class II installations and placed them under direct control of The Surgeon General.

Presently there are forty-six Class II installations with a total command strength of around 100,000. They include twenty-four general hospitals.

We know that this meeting will be mutually helpful. The program has been arranged so that there will be a chairman for each scheduled topic. After each subject is presented there will be an informal discussion and we hope that the discussion will bring into the open every matter of interest to hospital commanders. We want all your problems brought out at this conference. We will try to find solutions that can be put in effect immediately or take any necessary steps here in Washington.

There are a few points which we must bear in mind and which will be brought out in more detail during the conference.

1. The Surgeon General wants and expects our hospitals to be the best. We want them recognized as such and they will only be so recognized if they are, in fact, comparable with the best in contemporary medicine and only if they constantly improve. Construction must always be thought of not only as immediate but in terms of the future. Our equipment, likewise, must be up-to-date and the finest obtainable.

2. Our educational and training system must be kept at such a level that it meets the highest standards demanded by the professional groups in civilian life. It is accepted and recognized that patients receive the best care and treatment in hospitals which are teaching institutions. All of our general hospitals must be organized along the lines of, and be thought of as teaching institutions.

3. Commanding officers must consider themselves as representatives of The Surgeon General and of Army medicine in their relations with other federal and state medical agencies, and with the civilian profession. It is essential that there be the closest cooperation with civilian medicine. Every opportunity should be taken to encourage the mutual exchange of available teaching and professional facilities.

4. We have an immediate and continuing problem in insuring adequate specialist representation in our hospitals. We had the specialists for our needs during the war. During demobilization, we have separated to date some 44,000 medical officers. Of necessity this included a large proportion of doctors of the various specialties. To provide replacements for these specially trained men, we have planned as follows:-

a. To train, retrain, or refresh Army medical officers who had been on non-professional duties during the war years. Some three hundred of this group have been and are being exposed to professional medical practice and are currently becoming available for duty assignment.

b. To permit selected ASTP students to continue in residency training beyond their internship. Of this group there are roughly five hundred senior, or twenty-seven-months residents, and 1100 junior, or eighteen-months residents. These officers are now available and are assigned after completion of their Army indoctrination course at Brooke Army Medical Center. Their specialized ability must be utilized to the fullest.

c. To provide consultants. Civilian consultants are available for all general hospitals--we have the authority to employ their services. A rational program must be worked out at every general hospital to insure their proper integration into the hospital activities. By the intelligent use of these three categories of specialized personnel, our patients should be provided with superior medical attention.

d. There was one other method of providing continuing specialist attention and that was by:

(1) Retaining in the service medical officers with special MOS numbers classified as A, B, or C specialists, for a longer period of service than their brother officers.

(2) By freezing for an indefinite period by name, a limited number of essential specialists -- for example, plastic surgeons.

Of these two groups less than three hundred are now kept in the service. It is imperative that every one of these highly qualified doctors be actually on duty commensurate with his specialized ability and that every step be taken to replace him by a qualified person at the earliest possible date. Hospital commanders must consider this group as an individual group, know who they are, and know that they are properly assigned. Please let them know that their services are appreciated and that constant effort is being made to release them at the earliest possible moment. Special consideration should be given in recommending promotions for them.

Finally, we hope that you are familiar with WD Circular 138, 1946, and its supplement WD Circular 170, and that you have considered its implications so far as they apply to you. There is the divided responsibility in the working of this instrument. You must be familiar with the functions coming directly under The Surgeon General and the functions for which the army commander is responsible. If you cannot come to a satisfactory agreement with the army commander on matters for which he is responsible and as a result any problem is unsolved, please advise the Office of The Surgeon General and we will make every effort to help.

B. ARMY HOSPITALIZATION PROGRAM.....Lieutenant Colonel James T. McGibony, Officers and Civilians

1. Review of hospitalization program, including present and projected status of general hospital operation, Class II hospitals at Class I posts, and future plans.

Lt. Colonel James T. McGibony, MC, of the Hospital Division, Office of The Surgeon General, reviewed briefly the patient load in zone of interior hospitals at the peak of operation and at present, with the gradual decrease in the general - convalescent hospital system, and gave the projected status of general hospital operation. He made the following statements:

Probably the main point of interest is the hospital cutback program with which most of you are familiar. Last September, following VJ-Day, the hospital patient load was more than 300,000. As we all knew, this was to decline. A general plan of cutback in hospital installations was prepared. A quarterly program was initiated which planned that the first group of hospitals would close in December, the next group in March, the next group in June, and so on. The load of patients has now dropped to about 70,000. The original schedule of closure has been followed pretty closely. As you know, the convalescent hospitals as such, went out at the end of June and we picked up convalescent annexes. The patient load coming in from the zone of interior was increasing rapidly, so convalescent annexes were set up for all general hospitals. We believe patients cared for in this way will get back to duty quicker than under the older system.

The slides I have here will give you a good idea as to why convalescent hospitals were closed and how we hope to have the regional hospitals out by September and revert to general and station hospitals.

First slide (inclosure No. 1): Shows hospitalization data on all hospitals within the continental United States, including beds authorized, patients remaining, and beds occupied. It shows the effect of the various quarterly hospital cutback on the authorized bed capacity.

Second slide (inclosure No. 2): Shows the total patients remaining in hospitals including non-Army, both in the United States and overseas.

Third slide (inclosure No. 3): Shows the patient load in general hospitals proper, indicating the drop in peak load of the patients remaining.

Fourth slide (inclosure No. 4): Shows the peak load of patients evacuated from overseas and the diminution in the number of evacuees remaining.

Fifth slide (inclosure No. 3): Shows the convalescent hospital system and why the convalescent hospitals were closed out. In June the patient load in these hospitals was down to where it was not economical to keep patients at these installations.

Sixth slide (inclosure No. 3): Shows the regional hospital system which was in operation to take some of the load off the general hospitals during the war. These are being cutback and at the present time it is expected to have these hospitals out by the end of September and revert to the prewar general and station hospital system.

Seventh slide (inclosure No. 3): Shows station hospital load which at the present time is running about 8,000 patients.

Eighth slide (inclosure No. 5): Shows the number of Army patients evacuated to the United States by month; the peak month load being 59,000 patients. The number of evacuees has dropped down very rapidly to where we are receiving only about 1200 to 1500 patients and has resulted in a drop of from twenty-seven to six hospital ships.

Ninth slide (inclosure No. 6): Shows the number of patients received in Continental United States each week from overseas by water and by air.

Tenth slide (inclosure No. 7): Shows the total final disposition of patients.

Eleventh slide (inclosure No. 7): Shows patients on sick leave and furlough. This number at one time exceeded some 80,000. This has now leveled off to about twenty-five percent.

Twelfth slide (inclosure No. 7): Shows number of patients returned to duty which at the present time is approximately seventy-five percent.

Thirteenth slide (inclosure No. 7): Shows the number of patients given CDD.

Fourteenth slide (inclosure No. 8): Shows the estimate of patient load in general - convalescent hospital system, indicating the estimated load through September. The estimate for December is some 33,000 or 34,000 patients remaining.

A group of charts I have will give you some idea of what is in mind for the next group of closures. Of the sixty-five general hospitals at peak operation, we are now down to twenty-two of which three will close at the end of September. The original estimate called for at least seven hospitals to be closed by the end of September. At the present time, we will not be able to meet the seven but should be able to meet at least five of that number. The Veterans Administration has been slow to accept TB patients which are now in three Army hospitals. There are some 3,000 TB patients in Army hospitals at the present time.

First chart: Shows general hospital operation in June and what the general thinking is on the December cutback. This December cutback has not yet been sent to War Department for final approval.

It is planned that Mason will go back to the State of New York; Halloran will either go to the State of New York or to the Veterans Administration; Moore will go to the Veterans Administration; Wakeman will close due to the closing of the post, and Bruns will close if the TB load can go into Beaumont. Valley Forge has been scheduled for closure, but has at present 412 plastic cases. By keeping Valley Forge, we can close Halloran and Mason and at the same time take care of the plastic and NP load.

Second chart: Gives some idea of the development of the general hospital system after the outbreak of the war and the distribution of these hospitals.

Third chart: This is a copy of the slide which showed the general and convalescent patient load and the station and regional patient load, together with the anticipated load for the next few months.

Fourth chart: Shows the cutback in the regional hospital system with the closure of the hospitals.

Fifth chart: Gives an idea of what happened to the patients and patient load from June 1945 to June 1946 by the individual specialty.

Sixth chart: Shows the drop-off in surgical patients, although plastic surgery is at present still a major problem.

Borden General Hospital is now closing and the deaf patients will be moved to Walter Reed. Regarding the blind patients, there are forty at Valley Forge who will be sent to Old Farms. This raises the question as to whether Old Farms will be closed. At present there is a need for individual treatment for the remaining blind patients. It was tentatively set for closure in October and is now tentatively set for March, depending on the patient load in other hospitals.

The prisoner-of-war problem is practically over. All Italian patients, all Japanese patients and thirty thousand German patients have been repatriated. Only a very few remain.

2. Physical Medicine activities in Army general hospitals.

Lt. Colonel Benjamin A. Strickland, MC, Chief of the Physical Medicine Consultants Division, Office of The Surgeon General, was introduced by Colonel McGibony. Colonel Strickland reviewed the physical medicine activities in Army general hospitals. He stated that a number of questions had been submitted concerning long-term reconditioning and that a number of questions were sent in regarding the new department of physical medicine. Before answering the questions, Lt. Col. Strickland explained the policies of this department and some plans for its future. He quoted a physician at the American Medical Association convention recently, who believed that civilian hospitals would do well to follow the lead of Army hospitals in reconditioning, physical therapy, and occupational therapy. The recent upswing in the reconditioning system was improved by Bernard Baruch's donation to establish foundations for this purpose. Physical medicine is the combined use of physical therapy, occupational therapy, and reconditioning of convalescent patients. SGO Circular 53 gives the treatment program of convalescent patients in Army hospitals. In line with this a directive has been coordinated and upon approval of The Surgeon General will establish physical medicine sections in convalescent annexes and hospitals.

The following questions presented by the conferees were discussed by Lt. Col. Strickland:

Question 1: Will there be a department or service known as physical medicine to include what is now reconditioning and physical therapy, which is now under the surgical service?

DISCUSSION:

There was established in the Office of The Surgeon General, 15 April 1946, a Physical Medicine Consultants Division. This division was set up to include supervision of all activities pertaining to physical therapy, occupational therapy, and physical reconditioning. At the same time, a Convalescent Services Branch of the Hospital Division was established to include, among other things, all the other aspects of reconditioning, except physical reconditioning. It is obvious, therefore, that what was known as reconditioning was not included totally in the new Physical Medicine Consultants Division. It is planned in the near future to establish in all general hospitals a Physical Medicine Service, which will

include physical therapy, occupational therapy, and physical reconditioning. In addition, a Convalescent Services Section or Division is anticipated to be established in general hospitals. It is planned that Convalescent Services will include educational reconditioning and all other non-medical reconditioning activities along with certain other functions which are necessary in a general hospital. Great emphasis will be placed on close coordination and liaison between the Physical Reconditioning Branch of the Physical Medicine Service and the activities devoted to educational reconditioning (under Convalescent Services).

Answer: There will be a department or service known as Physical Medicine, to include physical reconditioning, physical therapy and occupational therapy. This service will be headed by a qualified medical officer.

Question 2: If Reconditioning Service is to continue under that name, will there be any unification with physical therapy or any closer relationship between the two?

DISCUSSION:

Since the Reconditioning Service will not be continued under that name, this question has been answered under question 1, above.

Answer: Although the Reconditioning Service will not continue under that name, there will be a close coordination, without unification, of the purely physical aspects of reconditioning with physical therapy.

Question 3: Is educational reconditioning on the way out?

DISCUSSION:

During and immediately following the war, reconditioning included a great variety of activities, many of which were aimed toward fitting individuals for return to civilian life. Many of the educational reconditioning facilities, such as extensive machine shops, automotive shops, agricultural projects, and other activities requiring heavy equipment, were necessary. Emphasis at present is being placed on reducing these extensive activities and facilities down to the point where the educational reconditioning program will include, for the most part, activities aimed at fitting the individual for return to military duty, rather than to civilian life. In line with this trend of planning, it may be said that educational reconditioning will be continued, but on a considerably reduced scale and in an objective direction aimed toward fitting the individual for return to military duty.

Answer: Educational reconditioning is being greatly reduced in scope, but will be continued under the new Convalescent Services Section.

DISCUSSION:

GENERAL HILLMAN: Will these departments of physical medicine be headed by a medical officer? The only person at my hospital qualified in this subject is a first lieutenant. There is a lieutenant colonel who has been trained in the reconditioning end of physical medicine, but he is not a doctor. I would like to know who should be made head of the department.

LT. COLONEL STRICKLAND: A doctor is required, but there are only two Regular Army officers trained in physical medicine. In the case at Letterman General Hospital the service should be organized so that there is technical supervision of the medical aspects of the program by the doctor, in this case the lieutenant. The lieutenant colonel should maintain a non-professional administrative supervision.

COLONEL ODOM: Is there something that can be done about the use of the word "diversion" in reference to neurotic patients? I think it is bad for the morale of patients and not good for the public interest.

LT. COLONEL STRICKLAND: The Physical Medicine Consultants Division is trying to find a new word for "diversion", and it should be forthcoming soon.

3. Functions of the Convalescent Services Branch.

First Lieutenant Robert A. Shoop, MAC, Chief of the Convalescent Services Branch, Office of The Surgeon General, reviewed the organization and functions of the Convalescent Services Division in Army hospitals.

Lieutenant Shoop distributed to the hospital commanders an organization chart (inclosure No. 9) which, he stated, shows the set-up which Colonel Strickland had just discussed in regard to Physical Medicine Consultants Division and Convalescent Services Branch. The latter will be called the Convalescent Services Division. It is to be noted that in that division all the non-medical activities are consolidated under one head. In some cases, the non-medical officer, who is chief of the reconditioning, can be used as the director of convalescent services. Educational reconditioning is not on the way out in function, however, consideration should be given to consolidating it with the Information and Education Branch. This is being coordinated with the War Department agencies concerned and will be published in the near future. The plan is

that the Medical Department will take advantage of the possibilities the Information and Education Division offers, including courses and use of material offered by them. Although it will not fully replace the expanded reconditioning division set up during the war, it will offer the opportunity to select any courses the patient desires to take. This division also offers the advantage of offering courses from the basic grammer school reading and writing to the college level, and the courses will be offered to patients in hospitals as well as duty personnel who want to make use of its advantages. The Veterans Administration is coming in under a public law passed by Congress which states that the Veterans Administration is responsible, from the time it is determined that a patient is on his way out, for his vocational guidance (reference Sec.VIII, WD Cir 168, 1946). Briefly, the mission of the Convalescent Services Division in hospitals will be to provide for the welfare and diversion of patients and duty personnel. The value of an organization such as this has very definite advantages and the value of such an organization can be readily seen. It also includes all those agencies which do non-medical work on the wards. It has worked well at this level.

General discussion of Army Ground Forces and Army Air Forces liaison resulted in various opinions among the conferees. Some thought it very helpful while others thought it no longer necessary. General opinion indicated future desirability of continuing this function.

4. Long-range hospital construction program, including activities of post-planning boards.

Lt. Colonel James J. Souder, SnC, Chief of the Hospital Construction Branch, Office of The Surgeon General, reviewed the long-range hospital construction program, including the activities of post-planning boards. Colonel Souder made the following statements:

The primary purpose of this discussion is to tell you something about the long-range planning of the Medical Department. In the past thirty-five years this country has grown increasingly interested in long-range physical planning, starting in the heavily populated areas of the East coast where the multiple problems of crowding, community obsolescence and continuing growth demanded planned community development in the interest of efficiency and economy. The idea spread from communities to counties, from counties to states, and from states to regions of several states having common interests. All of them operate in about the same way. A physical inventory is made; an analysis of the current and projected components of community life is made, that is, population, commerce, industry, communication, and recreation. Then a plan is made to direct the use of physical resources into a pattern which fits the community's current and projected needs. This pattern or master plan is implemented and enforced by zoning regulations, both the plan and the regulations being periodically revised as requirements change.

Capital expenditure budgets for highways, schools, public utilities, parks, and so on, are established in relation to the plan and cover periods of several years. They too are modified and adjusted each year to reflect changing needs.

The Federal Government has come to realize that it operates through its various branches a tremendous physical plant and is today vitally interested in developing a long-range planning program which will keep the physical plant in step with operating requirements, assure economy of operation, and obviate the haphazard development which has characterized the Federal establishment for so many years.

The Army has established post planning boards for all large posts. These boards are responsible for taking an inventory of the facilities the Army has and for laying down plans to guide future development. A ten year construction program is being developed in direct relation to this planning.

The Surgeon General in turn has established a post planning board within his office. It is the function of The Surgeon General's Board to define to commanders of Class II installations and other interested personnel the projected activities of the Medical Department at its Class II installations.

The board will shortly issue for The Surgeon General a statement of the mission of each Medical Department Class II installation in order to facilitate the work of the several local planning boards. This information will be circulated to army commanders and army surgeons since post planning must be related to the other post planning and regional planning in the area and since, regardless of the post mission, maintenance service will be provided by the army commander in whose area the post is located. Current War Department directives specify that master plans developed by post planning boards at Class II Installations will be routed through army commanders to the chief of technical service concerned. Here again, The Surgeon General's Board will act in reviewing master plans prior to their submission to the War Department. The board will also attempt to provide such technical service, other than that of planning technicians furnished by the Corps of Engineers, as the hospital problems require and will attempt to circulate to all hospitals planning improvements developed in any part of the system.

As for current plans of the Medical Department based on the strength of the Army as it is now projected, The Surgeon General is looking to the development of a chain of twelve modern general hospitals providing a total of some 20,000 beds, of which 15,000 are general hospital beds in the strict sense, the balance being beds held available for Veterans Administration beneficiaries and beds required for station hospital cases

in those instances where general hospitals are located on Class I posts. The projected locations of these hospitals follow population areas, troop training areas, and civilian medical centers. The first three units are planned for locations which are considered important regardless of the ultimate size of the Army: An East Coast terminal hospital in New York, a West Coast terminal hospital in San Francisco, and a new unit at the Army Medical Center to be built along with the proposed new Army Institute of Pathology as the nucleus of the Army Medical Research and Graduate Teaching Center. The next elements to be provided are a modern plant to replace William Beaumont General Hospital, and a modern plant to replace the largely temporary facilities at Oliver General hospital. Next are expansions at Fitzsimons and at Brooke. By that time it should be 1952 or 1953 and we should know the size of the postwar military establishment. If current projections are accurate, we shall undertake at that time to replace Madigan with a new hospital, probably nearer to the Seattle Port than Fort Lewis, and assign the present Madigan plant to station hospital use. At the same time we shall develop an additional general hospital in the Southeast to replace Pratt. Finally, at the end of the program, we shall replace the present Percy Jones plant with a new hospital in the Chicago area, and the McCornack plant with a new hospital in Southern California. That summarizes the ten-year general hospital program.

As specific plans for these new hospitals are developed, your comments and suggestions will be solicited. The Surgeon General has been successful in implementing a War Department policy whereby these hospitals will be planned by the most competent civilian architects available. Each hospital will be planned not only on the basis of the mission assigned to it but in close harmony with its site, local climate, and local planning customs. We took to the development of hospitals which are adequate for immediate needs and which at the same time can be substantially expanded without resulting inefficiency or operating inconvenience. Everyone in the Medical Department is familiar with the unfortunate story of Walter Reed General Hospital and how it grew. This hospital, which should be as much to our credit physically as it is professionally, is probably the worst "hodgepodge" of bad planning ever concocted for a hospital. There was at one time an overall development plan for the hospital but requirements changed to the extent that the plan was no longer adequate. At that time the damage started. Without benefit of a revised, comprehensive plan, piecemeal developments and alterations were undertaken. An active planning board with normal foresight and the initiative and ingenuity necessary to keep the plan abreast of the time could have saved the day. That kind of foresight and that kind of ingenuity are necessary today and tomorrow, next year and always, if our hospitals are to be kept modern, because few physical plants are subjected to the continuing changes which the development of the practice of medicine forces in hospitals. Such physical changes obviously cannot close until there is an end to the ingenuity of the medical profession. Our new hospitals, such as the new Tripler, which is currently under construction, are planned for a minimum expansion

in capacity of thirty percent. It is the responsibility of the hospital planning boards and The Surgeon General's Planning Board to make certain that the expansion possibility is not violated and that the expansion plan is re-examined periodically to keep it in harmony with changing professional requirements and changing concepts of planning and building.

There has arisen a question of whether planning boards should function at those hospitals which are scheduled for replacement. This office firmly believes that they should. We are currently going through a period of adjustment which will last for at least another year. Subsequent to that it will be some time before new hospitals are completed. It may even be many years, depending upon how the Congress regards the Army's ten-year plan. At those hospitals which are regarded as interim hospitals, construction, repairs and replacements should be urged by the board when they are needed for effective patient care and comfortable personnel housing, but they should be reviewed in relation to the anticipated period of operation of the present physical plant.

At both interim and permanent hospitals there is an important continuing problem of relationship to adjacent posts and adjacent civilian communities. It is the responsibility of the planning board to be sure that post plans are coordinated with those of adjoining communities to the mutual benefit of each. The community no more wants the Army to establish a heavy traffic outlet right at the gates of its schools or play grounds than the Army wants the community to establish a trash dump across the fence from the hospital. There should be a mutual familiarity with long-range plans of neighboring installations, whether military or civilian.

We have had almost two hundred years of operation without long-range physical planning. Our hospital plant is not one to which we can point with pride. In establishing a long-range development plan and continually advocating its implementation, The Surgeon General has started us on the road to a thoroughly efficient and admirable hospital system. The Medical Department has, in the development of this system, an opportunity to offer patient care and patient comfort that is unbeatable, and an opportunity to attract to the Medical Department the best available of professional personnel.

There is one other matter. The Central Welfare Fund has at the present time a large amount of money which it is in the mood to dispense for worthy projects. You are currently being subjected to another questionnaire in an effort to find what athletic, religious, and recreational projects your posts have which might be built with non-appropriated funds. Such funds can be used for many things, such as: swimming pools, playing fields and chapels. We understand that post exchanges and theaters are not regarded favorably because of the availability of operating surpluses for construction of such buildings. In filling out the questionnaire you should divide your projects into two categories, first, those

which could be accomplished by use of troop labor, assuming you have non-appropriated funds for materials; second, projects which should be built by contract.

General Bliss stated that he has visited the new Tripler General Hospital several times and that it is progressing satisfactorily. He stated that in his opinion it has every known modern convenience and every aid to efficient and economical maintenance and that, without being ornate or elaborate, it will be the best hospital in the world. He said the hospital will be a real credit to the Medical Department and that everyone in the Medical Department will be proud of The Surgeon General's accomplishment in getting this splendid, permanent hospital initiated during the War.

5. Maintenance, repair and utilities in Army hospitals.

Brigadier General John S. Bragdon,CE, Chief of Construction, Office of the Chief of Engineers was introduced by General Bliss. He made the following statements:

The vital mission of the Medical Department has been recognized by the Corps of Engineers throughout the War. With the cessation of hostilities this mission has not diminished, nor have the responsibilities of the Corps of Engineers in connection with the execution of this mission diminished. Providing the finest medical care for the sick and wounded in the best-equipped hospitals is an important responsibility of the War Department. It is incumbent upon all services concerned with the carrying out of this responsibility to insure that the high standards of hospitalization provided during the war are maintained. Towards this end, the Corps of Engineers will continue to do its part.

The purpose of repairs and utilities at general hospitals, and at all army hospitals, is to provide a service. This service includes the maintenance and repair of buildings, structures, and facilities, the operation of utilities, and the provision of fire protection service.

During the war, standards for the accomplishment of repairs and utilities were necessarily limited to the Spartan simplicity measures set forth in AGO Memorandum 100-10-43. In general, these standards were not as rigidly applied to Army hospitals as they were to other types of installations. However, in 1945, a great amount of deferred maintenance was accomplished at general hospitals. No special funds were allotted for this purpose, rather, regular Engineer Service, Army Project 300 funds allotted for normal recurrent repairs and utilities work were used. The purpose of accomplishing this deferred maintenance was to raise the wartime standards of general hospitals to approximate those normally adhered to in peacetime.

Specific items covered in this deferred maintenance were: the installation of floor covering where pine or other poor quality floors had been originally installed; exterior painting of all temporary buildings; interior painting of buildings except for unlined surfaces or unplastered interior masonry surfaces; sealing of interior exposed framing and installation of insulation; provision of new equipment and rearrangement of existing items of equipment for diet kitchens; inclosing open covered walkways and corridors; and expansion, renovation and establishment of good quality lawns in the immediate vicinity of wards and administration buildings, barracks and quarters, and establishment of a plan of landscape development. In addition to these items, walks were increased in two-foot increments to accommodate wheelchair or pedestrian traffic; road and drive surfaces were increased to meet standards comparable to urban construction; electrical and heating systems were improved; irrigation, dust and erosion control work were also accomplished.

It is important to note that while this work was undertaken for general hospitals, the same situation did not prevail with respect to regional and station hospitals, nor with respect to other types of installations. At these facilities despite the accumulation of a great amount of deferred maintenance the wartime standards of maintenance and repair had to be adhered to, for lack of adequate funds, also, for lack of labor and materials.

On 7 May 1946, the wartime standards of maintenance and repair were rescinded by WD Memorandum 100-46, subject: "Repairs and Utilities Standards". The purpose of Memorandum 100-46 was to permit the raising of standards of postwar installations so as to ultimately "equal the maximum economical standards normally applied in good commercial, municipal, or state practices for comparable facilities." To permit the carrying out of this purpose, Congress has authorized the inclusion of a $50,000,000 item in the Engineer Service, Army appropriation for the Fiscal Year 1947, for the initiation of the War Department Deferred Maintenance Program. Of this $50,000,000, approximately $10,000,000 has been earmarked for regional and station hospitals.

While for all types of installations, other than general hospitals, the deferred maintenance program has just been authorized, for general hospitals the current mission of repairs and utilities is to maintain to the maximum the standards initially set up last year.

Having discussed increased maintenance for general hospitals and the War Department Deferred Maintenance Program, let us for a minute, discuss comparative costs of maintaining general hospitals. Chart II (inclosure No. 10) will serve to show the average per square foot of building maintenance costs during the Fiscal Year 1946 for four general hospitals which were selected as being representative. The first installation shown is William Beaumont General Hospital which is located on

Fort Bliss, Texas. During the Fiscal Year 1946, the average unit cost per square foot of buildings shows that for William Beaumont General Hospital 7.23 cents were spent, while for Fort Bliss proper, exclusive of the hospital, 2.54 cents were spent.

The next hospital shown is Letterman General Hospital located on the Presidio of San Francisco in California. Letterman General hospital spent an average of 12.66 cents per square foot on building maintenance, and the Presidio of San Francisco, exclusive of the hospital, spent 3.29 cents per square foot.

Tilton General Hospital is shown next, and is located on Fort Dix, New Jersey. Fort Dix, exclusive of Tilton General Hospital, is shown as spending 6.34 cents per square foot on building maintenance, while Tilton General Hospital spent 11.85 per square foot.

The last hospital shown is Lovell General Hospital, located on Fort Devens, Massachusetts. Lovell General Hospital spent 17.04 cents per square foot on building maintenance, and Fort Devens, exclusive of Lovell Hospital, spent 3.24 cents per square foot.

From the general hospitals selected and shown on Chart II as being representative, it will be noted that the average unit cost per square foot for building maintenance at these hospitals is from two to five times greater than the average unit costs for the installations upon which these hospitals are based. The great difference is accounted for largely by the extensive deferred maintenance program of Fiscal Year 1946.

Chart III (inclosure No. 11) shows the comparative maintenance costs for buildings and improved grounds for the Fiscal Year 1946. The average of all Class I and II installations was taken and compared with the average for all general hospitals. The average maintenance costs for all buildings at all Class I and II installations is 3.82 cents per square foot on a national average. The average maintenance cost for all buildings at all general hospitals is 11.32 cents per square foot. The 11.32 cents, average per square foot of buildings maintenance cost of general hospitals is included in the 3.82 cents national average.

The average maintenance cost for all improved grounds at all Class I and II installations is $11.38 per acre on a national average. The average maintenance cost for improved grounds at all general hospitals is $125.06 per acre, over eleven (11) times as much as was spent on the national average, and yet the $125.06 average per acre of general hospitals is included in the national average of $11.38 per acre.

Having now covered some comparative facts about past operations let us take a quick glance at present and future operations. The custodial

services policy of the War Department was recently issued 28 June 1946 in Section I, WD Circular 192, 1946. While custodial services are vital to the proper functioning of all installations, from a health and morale standpoint, they are more so to hospitals. As part of his repairs and utilities responsibilities, the post engineer is responsible for providing civilian personnel for the accomplishment of custodial services in hospital administration buildings, including inclosed walks, wards, and clinics. However, hospital complement and other available hospital personnel, including civilians, are to be utilized to the fullest extent. At the present time, the Repairs and Utilities Division, Office of Chief of Engineers is conducting an intensive training course for the training of all supervisory employees engaged in custodial services to insure the execution of this responsibility with the maximum of efficiency and economy.

The matter of maintaining and operating greenhouses at general and convalescent hospitals as part of the convalescent and reconditioning program for patients has recently been decided and published as change 2 to TM 5-600, 5 April 1946. The post engineer, as part of his repairs and utilities responsibilities, is responsible for the maintenance of greenhouses, the furnishing of utilities services, and the furnishing of qualified personnel to accomplish this work. The furnishing of greenhouse supervisory or operating personnel, and of such tools, equipment, seeds, cuttings, supplies, etc., as may be necessary, is a responsibility of The Surgeon General.

Turning now to the question of engineer equipment in permanent Army hospitals, The Surgeon General on 7 May 1946 requested the Chief of Engineers to investigate the adequacy of the engineer equipment at all post-war general hospitals. As a result of this letter, a conference was arranged between representatives of the Office of The Surgeon General and of the Office of Chief of Engineers to establish a program for replacing obsolete or second quality equipment with the best equipment available. It was determined at this conference that the primary equipment under consideration was kitchen and mess equipment, including refrigerators. Due to the various procurement, assignment, and maintenance and repair responsibilities involved, the Quartermaster General was requested to participate in the program. As a result of further correspondence and additional conferences, and inspection and planning program for kitchen and mess equipment has been established. At the present time, it is tentatively planned that the actual inspections be started around the middle of September, which inspections will be carried out by inspection and planning teams, comprised of representatives of The Surgeon General, the Quartermaster General, and the Chief of Engineers. Based upon the results of the inspections of these teams, equipment replacements will be made.

6. Relationship of the Bureau of the Budget to Federal hospitals.

Mr. Leroy Gifford of the Hospitalization Section, Bureau of the Budget, was introduced by General Bliss. Mr. Gifford spoke on the relationship to the Federal hospitals.

I understand that it was the desire to have an informal talk on the relationship of the Bureau of the Budget with the general hospital program of the Federal Government and army hospitals in particular, There are three points to that title as you will see. To understand the relationship of the Bureau of the Budget to a hospital program under the Federal Government and to army hospitals in particular, it is best to begin with the relationship of the Bureau of the Budget and the Federal Government. The Bureau of the Budget originally was an executive office of the President. It is a staff agency and its principal function is to act as a representative or agent to the Chief Executive in problems of coordination and management. That means that the Bureau of the Budget is interested not only in hospitals but in all other management activities of the Federal Government.

Hospitals themselves constitute such an important part of the entire Federal program that an entire section of the Bureau of the Budget is devoted to that particular function. You will realize, of course, that in handling the many problems that confront us we have to specialize, and in the matter of hospitals and medical programs we specialize functionally. In some other instances a group will handle an agency with all its activities. A number of groups combined into a section will concern themselves with a particular function. You will see by the position of the Bureau of the Budget in the Federal Government and its relationship to the Chief Executive that we have a wider field than is sometimes assumed. I know that members of the staff of the Bureau of the Budget are sometimes jokingly accused of having taken this or that away from some individual, but at the same time we have a great many activities that come outside of the field of appropriation estimates and sometimes suggest that some things may not be needed. Individual projects are welded into a harmonious pattern. That implies management in a broad and general sense and we like to define our work in terms of the approach of management rather than in the more narrow accounts concept of going at a budget. We do have the responsibilities that are ordinarily implied in budget work and a good deal beyond that. It is for that reason that we set up in the Bureau of the Budget a section that specializes in hospitals and medical programs. The members of that section are keeping constantly in touch with the Federal hospital program. We analyze the resources how the loads are being carried and must be prepared to answer all sorts of questions that come in. Our mission is varied indeed. If someone on the outside writes a letter to the President concerning a hospital question it is likely to be answered in the Hospital Section. If it is a budget matter it comes to us for analysis

and recommendation. If it is a proposal to build a new hospital we must be prepared to answer questions relating to its construction.

Probably most of you are familiar with the figures of the hospital program of the Federal Government. I brought along a brief reference as to the number involved. I am speaking of what you call general hospitals -- army named general hospitals omitting station hospitals and the various dispensaries. I mean fully staffed general hospitals. At the present time the Veterans Administration is the largest Federal agency operating about 92,000 beds. That program is already planned for expansion of 150,000 beds by 1950. 1950 is the target date in making studies of Veterans Administration needs. In round figures about 150,000 beds will be needed at that time. A round figure of 300,000 beds is in the Veterans Administration plan. That is a long way in the distance. It might never be reached. It is more an immediate goal according to the studies made thus far. Perhaps by 1960 or 1965 the Veterans Administration might be operating more than 250,000 general hospital beds. The Veterans Administration will be the largest single hospitalizing agency for some time to come. The Army now holds second place with 58,000 beds and the Navy 44,000 beds. Then there are a group operating under the Public Health Service that includes marine hospitals, St. Elizabeth's Hospital, narcotic hospitals, and Freedman's Hospital. All are grouped together under the Public Health Service. Together they comprise 17,500 beds. Lastly, there are three small groups: Indian Service hospitals, Bureau of Prisons hospitals and the District of Columbia hospitals. These three together have about 7,900 beds at the present time. The agencies I have indicated account for about 220,000 beds which are now being operated in general hospitals by the Federal Government. That is a large hospital program; so large that we feel justified in treating it as a special function.

One of the principal management tools that the Bureau of the Budget uses, and of course everyone uses that tool in management, is exact information - statistics. I never did like that word "statistics". It implies something dry and more dusty than the figures that one uses in every day administration. We do get reports generally on a monthly basis. In operating hospitals over a period of years we have tried to get those reports on a uniform basis, for they are indispensable to us and to you. Uniform definitions supply us with the information so that when we speak of patient load it will mean the same thing whether Army, Navy, Publis Health Service, or Indian Service. Most reports are on a monthly basis with an annual summary. These are the principal equipment in answering questions that arise in regard to hospitalization and in making recommendations to the President concerning hospital activities. We feel that in any management approach, material of that kind is indispensable. Most of the reports that we get represent a summary of information that the agency has to prepare and keep current for its own use. It may be that some reports involve special work on the part of the agency. I don't believe that very many of them do. Essentially, we need the same information to solve a problem relating to a hundred hospitals as a group.

The Federal hospital program divides itself into two parts. We treat them as separate parts. One is the location and construction of new hospitals. The other is the operation of hospitals already in existence. During the past six years the Federal Government has been engaged in a very active program of hospital expansion. It has been mostly an Army and Navy expansion. With the ending of the war the Veterans Administration has expanded. Planning a hospital program from the standpoint of construction is quite different from the operation of one. For one thing it is necessary to work farther ahead. The target date is 1950. It is necessary to look quite ahead because of the lag of time. First, there is the appropriation of the money and then the contracting and scheduling of the hospital for use. We saw plenty of that during the war and you got much faster action than is possible to get now. Right now an agency such as the Veterans Administration is trying to expand. Hospitals are included in the budget now being prepared for the fiscal year 1948. At the present rate of speed of construction, present hospitals will not be ready before 1950. That is a long spread and complicates the matter of planning.

In solving problems regarding the hospital construction program the Bureau of the Budget has the assistance of the Federal Board of Hospitalization with which many of you are familiar. It consists of heads of the principal hospital operating agencies under the chairmanship of the Director of the Bureau of the Budget. All proposals for new construction or expansion of existing facilities must be presented to that board for analysis and recommendation. The Federal Hospitalization Board has been actively screening projects of this kind particularly for the last three years. The benefits of such a screening process has been tremendous. When an agency wants to build a hospital it has to specify to the Board where and what it will be and how large and of what type. It must be justified before the board. This has a very healthy effect on planning at agency level. Another great advantage has been that the Board has been able to review the proposals of all the agencies and recommend coordinated action. There is no question in my mind that the work of that board has saved the Federal Government hundreds of millions of dollars. And, it appears from the experience we have had the Federal Hospitalization Board can function without impairing any individual agency. Here is one little illustration of what can be done by coordinating the hospital resources of the Federal Government - turning over to the Veterans Administration surplus Army and Navy hospitals. Up-to-date 28 Army and Navy hospitals have been transferred to the Veterans Administration. Those hospitals had a normal capacity of 45,000 beds and were transferred fully equipped and stocked. The Veterans Administration proposes to use 20,000 beds in the near future with 25,000 in reserve. At lease six of the above hospitals will form a permanent part of the Veterans Administration system. They are so located and constructed that they can be used permanently with little modification. In some

cases the reservation and utilities of a temporary hospital will be put to permanent use with new hospital buildings. Others will eventually be replaced with new hospitals at other locations. The importance of this use of surplus hospitals can hardly be overestimated. Without them the Veterans Administration could not possibly meet its present urgent demands while waiting for its own hospitals to be built.

In approaching the current operating problems of Army hospitals we realize that you have your own particular difficulties. Rapid demobilization of army personnel has caused serious dislocation of professional and technical staffs at a time when patient loads continued at high levels. Perhaps the worst of that is over. We are very much alive, however, to the fact that nobody sympathizes with an agency that has to contract. It takes very careful planning to abandon certain hospitals and to keep others going. In approaching the operating problems of military hospitals we recognize something else, also, which does not apply to any hospitalizing organization, and that is that a system of military hospitals has to be ready at all times for expansion. We recognize, too, that it is necessary to keep enough trained personnel in your general hospitals so that you can supply new organizations. Those are peculiarities of military hospitals which do not apply to hospitals of some other agencies.

Thus far I have said nothing about the dollar economy and I am not going to say anything about that because we feel that in approaching problems of Government from a sound standpoint the matter of economy in the military sense are taken care of. The matter of economy will take care of itself. It is only fair to warn you, however, that in the future the Bureau of the Budget will scrutinize appropriation estimates for hospitals more closely than it did during the war. We realize that with a war in progress it was impossible to estimate patient load or personnel requirements or any other major facts that determine the size of a hospital program. Now that you are in a position to estimate those things more closely we shall ask more questions. I am sure you will see that your budget officer will be prepared to answer those questions. On one point you may be sure that we will be in complete agreement -- the high standards of medical and hospital care must not be impaired. Thank you.

Questions submitted by hospital commanders and referred to the Hospital Division for answer were presented by Colonel McGibony.

QUESTION 1: Can general hospitals receive a six month notice as to future patient loads, with a breakdown by classification?

DISCUSSION:

For planning purposes, it is essential that future prospects regarding patient loads be known as far in advance as possible. The patients in a hospital can be assayed, but calculations are repeatedly upset by sudden transfers of large numbers of patients from other

hospitals. The time is past when general hospitals can receive convoys such as were received during wartime, without advance planning in regards to bed space and medical care. Six months would provide an adequate period for such planning.

ANSWER: Such a long forecast would be of doubtful value. A three month forecast has been distributed to each of the hospital commanders.

QUESTION 2: Are separate planning boards required for the post of Fort Custer and Percy Jones General Hospital in Battle Creek, or is a single planning board adequate to cover all activities under the control of the Commanding General, Percy Jones General Hospital?

DISCUSSION:

Paragraph 3, AR 210-20 states that "Commanding Generals answerable to the War Department will cause to be established at each post, camp or station a permanent Post Planning Board." Prior to the deactivation of the Sixth Service Command and the change in the status of this command, a single planning board existed, covering activities of Percy Jones Hospital Center. Subsequently, the directive establishing such a board has been rescinded by the Commanding General, Fifth Army, with the substitution of a new directive ordering the establishment of a new planning Board at "Fort Custer, Michigan". It is believed, however, inasmuch as there are no activities at Fort Custer, other than those of Percy Jones General Hospital, that single planning board, covering all hospital installations would be both adequate and desirable. This is not possible until the present confusion has been eliminated. (Submitted by: CG, Percy Jones General Hospital.)

ANSWER: The post is scheduled for continued use. Therefore, the Commanding General, Fifth Army is justified in establishing a planning board. Percy Jones General Hospital should maintain an active planning board for the Battle Creek establishment only, in accordance with AR 210-20. The Commanding General, Percy Jones Hospital should seek membership in the Fort Custer Board as having a primary interest there. He should invite representatives of the Fort Custer Board to sit with the Percy Jones Board as associate members.

QUESTION 3: Who has the responsibility for final approval of construction projects at general hospitals, army headquarters or the Office of The Surgeon General?

DISCUSSION:

Both army headquarters and the Office of The Surgeon General have asked for estimates and detailed information regarding construction projects at this installation, thus, creating uncertainty as to which of these agencies can furnish an authoritative decision regarding the status of a given project. (Submitted by: CG, Percy Jones General Hospital.)

ANSWER: a. References:

WD Circular 343, 1945.
WD Circular 45, 1946
WD Memo 100-46 , 4 March 1946.
WD Memo 100-46 , 2 April 1946.
TM 5-600
WD Memo 100-70-1

b. Basically, all construction is approved by the War Department except maintenance repair and utilities projects costing less than $10,000.

c. Commanding officers desiring to submit projects must secure authority for submission prior to directing local engineers to prepare them. This authority may come from either the army commander or The Surgeon General and may be written or verbal.

d. New projects are processed through engineer channels, that is, district engineer, then army engineer, to the Chief of Engineers, who obtains approval of The Surgeon General with regard to planning and approval of the War Department with regard to expenditure.

e. Repairs, alterations, conversions and extensions of existing buildings may be approved by army commanders as a part of the housekeeping function provided the project cost does not exceed $10,000. Projects exceeding $10,000 in cost must be forwarded by army commanders thru the Chief of Engineers to the War Department. It should be noted that post commanders no longer have authority to approve new construction projects costing less than $1,000. Alteration projects costing less than $1,000 continue to be approvable by post commanders.

f. Obviously, all construction must conform to War Department construction policy.

g. Budgeting of new construction at general hospitals is handled by The Surgeon General. Estimates should be submitted directly to this office in the case of general hospitals located on Class I posts, information copies of this material should be furnished the army headquarters concerned.

QUESTION 4: AR 210-20, 11 June 1946 provides for establishment of post planning boards at all stations, "that have been either tentatively or finally selected and designated, by the War Department as being installations planned for permanent or prolonged retention." Has McCornack General Hospital been selected or designated by the War Department for retention as noted above? If it has been so selected then why has not a planning board been established by proper authority? (Submitted by: CO, McCornack General Hospital,"

ANSWER: McCornack General Hospital has just been designated a 1A station. As such, it should have a post planning board and proper instructions will be issued as soon as the re-classification notice is formally issued.

QUESTION 5: Is the personnel allotment for post engineer based on requirements for maintenance, repair and operation only or does the personnel allotment allow for a percentage of new work and alteration to be done by engineer personnel without deferring maintenance and repair? (Submitted by CO, McCornack General Hospital.)

DISCUSSION:

Cost budget in relation to new work account. -- Assuming the limitation of cost budget set by Sixth Army is for the purpose of minimizing the number of major new work project, it would appear that revision of the definition of this account as contained in WD TM 5-602, should be made in view of the numerous recurring installations that are absolutely necessary, and which must under present definition be costed to this account. Since this station is a hotel conversion minor installations are constantly required which under present procedure reflect distorted cost in the new work account. Station estimate for present six months in this account was $4,800.00, Sixth Army approved $2,000.00. An increase in this account will not be approved unless detailed justification is shown. Detailed justification would involve unjustified engineering analysis and cost estimates. Examples of recurring new work costs: Installation of kitchen equipment, installation of electric outlets, installation of phone buzzers, installation of hasp and lock on door or cabinet, removal of light fixtures, removal of partitions, windows or

doors. Any job that is not classified as maintenance repair and operation is considered new work. All items are costed at prevailing date, i.e., EM labor, free material, etc.

ANSWER: The answer to this question is contained in a WD circular to be published. In general, new work should not be undertaken by the post engineer at the expense of deferred maintenance. Efforts are being made to secure authority for post engineers to use purchase and hire on such jobs.

QUESTION 6: Request that a definite directive as to the position of the army in the channels of command in relation to Class II installations (especially named general hospitals), be issued (Submitted by: CO, Murphy General Hospital.)

ANSWER: WD Circulars 138 and 170, 1946, cover this matter.

QUESTION 7: At the present time there are approximately 130 to 140 cases of poliomyelitis residuals under treatment at this hospital. Special facilities have been set up for their treatment, which is supervised by specially trained officers, nurses and physical therapists. However, when allocation of beds is received from The Surgeon General, no mention is ever made of poliomyelitis, beds being allocated for arthritis, deep X-ray and radium therapy, Veterans Administration and Service Command only. (Submitted by: CO, Army and Navy General Hospital.)

ANSWER: The number of cases is relatively small and no code was established. It will be the policy to transfer chronic residual polio cases to Army and Navy General Hospital.

QUESTION 8: It appears very difficult to effect various repair, maintenance and needed construction programs through the army headquarters, formerly service command headquarters. The roofs of the two main wings of this steel and concrete structure have been leaking for the past six or eight years. Since early in 1946 the post engineer at this hospital has been attempting to get authorization for the repair of these roofs, without any definite action so far. Various so-called experts from Army Headquarters advise different remedies, with the result that nothing is accomplished. (Submitted by: CO, Army and Navy General Hospital.)

ANSWER: In cases where inadequate engineering service is obtained from army headquarters the following procedure is recommended:

a. Direct contact with the army surgeon enlisting his support in securing necessary service.

b. Official report to The Surgeon General detailing the difficulties encountered. Such reports will be taken up with the Chief of Engineers and concerted efforts will be made to secure the desired service.

QUESTION 9: This hospital follows the procedure outlined in WD Circular 215, 1945, in forwarding officers' clinical records and VA Form 526 to the Veterans Administration. Further directives on this subject are contained in WD Circular 474, 1944, WD Circular 36, 1946, and WD Circular 148, 1946. All these directives state that the Clinical Record and VA Form 526 will be forwarded to the Regional Veterans Administration Office. However, it is the opinion of this headquarters that WD Circular 36, 1946 and WD Circular 215, 1945 conflict somewhat. WD Circular 36 states that VA Form 525 will be forwarded immediately following the officer's separation. WD Circular 215 states that VA Form 526 will be forwarded with the clinical records after authority has been received from The Adjutant General to forward the clinical record. Officers are appearing before an army retiring board and being separated, then writing to this headquarters requesting that their application for pension, VA Form 526, be forwarded to the regional Veterans Administration office. This office is not forwarding 526 as they request, and as is provided by WD Circular 36, but is holding it until authority is received from The Adjutant General to forward the clinical record which is the procedure outlined in WD Circular 215, 1945. In a number of cases it is several months before The Adjutant General authorizes this headquarters to release the clinical record. (Submitted by: CO Army and Navy General Hospital).

ANSWER: The procedure outlined as the one currently followed by the questioner with respect to forwarding of specified clinical records and VA Forms 526 to the Veterans Administration is the correct procedure. In the case of officers being separated for disability, The Adjutant General's Office desires that the clinical records and other records required by the Veterans Administration be held by the hospital until their release is authorized by The Adjutant General. War Department Circular 36, 1946, on the one hand, and WD Circulars 474, 1944 and 215, 1945, on the other, are not in conflict since the latter ones pertain to officers separated for disability and the former (WD Cir 76, 1945) pertains to

separations at separation centers and to separating enlisted men at other than separation centers. With respect to the occasional delay referred to in obtaining authority from The Adjutant General for release of the records in question, it is suggested that vigorous follow-up measures be initiated on unanswered requests.

QUESTION 10: In spite of many letters to The Surgeon General reporting that fact, the Veterans Administration continues to be three or four months in arrears for payment of subsistence charges for veterans treated in hospitals. (Submitted by: CO, Army & Navy General Hospital)

ANSWER: Hospital Fund has always compensated for this by additional grants. The Veterans Administration Fiscal Officer is familiar with this situation.

QUESTION 11: In newly activated general hospitals is it advisable to set up full long range planning board activities without definite assurance that the installation is to be permanent? (Submitted by: CO, Pratt General Hospital.)

ANSWER: None of our general hospitals now classified 1A can be deactivated prior to 1949 according to present plans. Each such hospital should have an active planning board which can evaluate its construction and major alteration needs for the anticipated period of continued use. The Surgeon General will in the immediate future issue to all concerned a definition of mission and of anticipated period of continued occupancy.

QUESTION 12: What changes or modifications, if any, in Corps of Engineers policies and criteria for planning at post installations will be recommended by The Surgeon General to adapt such planning for named general hospitals? (Submitted by: CO, Pratt General Hospital)

ANSWER: The Surgeon General has asked all Class II commanders to submit comments on postwar planning criteria issued by the Office of the Chief of Engineers. These comments are welcome at all times and any inadequate or unapplicable criteria pointed out will be taken up with the Chief of Engineers in order that his manuals may be changed.

QUESTION 13: Is it the policy of The Surgeon General to require an emergency electric power plant installation in all general hospitals to back up the primary electric power supply from public utilities? (Submitted by: CO, Pratt General Hospital.)

ANSWER: Neither the Office of The Surgeon General, nor the Office of Chief of Engineers has a fixed policy in this matter due to the wide variation in local conditions. In any case where power failure is normally expected, The Surgeon General and Chief of Engineers require stand-by generating equipment adequate to light critical areas and to operate critical equipment such as elevators, boilers and pumps.

QUESTION 14: Is it the policy of The Surgeon General to require separate post engineer establishments in general hospitals even though nearby army activity is already performing this function?

ANSWER: War Department policy and common sense dictate the unification of maintenance facilities for adjacent stations. The Surgeon General strongly recommends the assignment of a post engineer liaison officer (or competent civilian engineer) to the hospital staff in those cases where general hospitals are dependent upon other stations for post engineer service. The Chief of Engineers is sympathetic to this recommendation but has not put it in effect in all cases due to personnel shortages.

QUESTION 15: Is approval of your office required for expenditures from hospital fund in excess of $1,000.00 for individual welfare projects for patients? (Submitted by: CG, Fitzsimons General Hospital.)

ANSWER: Yes! Paragraph 10, WD Circular 214, 1945 is in effect. Approval formerly required from service command for construction, maintenance, and purchase of furnishing for building and other facilities of over $1,000.00 is now the responsibility of The Surgeon General.

QUESTION 16: What are the limitations imposed upon the hospital commander for the definitive surgical and medical care in treatment of Veteran Administration patients?

ANSWER: The limitations are the same as the limitations on treatment of military personnel as outlined in WD Circular 12, 1946.

QUESTION 17: What type of operative procedures or medical procedures is he limited to?

ANSWER: The type of operative procedures is listed in WD Circular 12, 1946.

QUESTION 18: What is the length of the hospitalization that the Veterans Administration patients are going to be limited to?

ANSWER: Length of hospitalization - Veterans Administration bed credits are not designated for domiciliary type cases and as a general policy the length of hospitalization would be similar to the policy for military personnel as outlined in WD Circular 12, 1946.

QUESTION 19: In what ways is the mess going to be reimbursed for rations; in turn, the hospital fund reimbursement. Will a ration allowance be the same for Veterans Administration patients as it is for military patients?

ANSWER: Authority for the admission in army hospitals of beneficiaries of the Veterans Administration is prescribed in Par. 6u, AR 40-590. Subsistence charges for such personnel are governed by the provisions of Par 12A (1) (b) 13, AR 40-590, with a footnote which is quoted as follows: "Subsistence charges for these personnel will not be collected from the patients but either will be billed by the commanding officer of the medical installation concerned direct to The Surgeon General of the Army, or will be otherwise collected in accordance with instructions from time to time issued by The Surgeon General."

The above-cited Army Regulations are currently implemented by SGO Circular 13, 14 May 1946. Notwithstanding the fact that this directive was distributed only to general hospitals and hospital centers, the Fiscal Division of this office advises that a copy of this circular is forwarded to an army hospital as soon as information has been received that the hospital concerned has been allotted beds for Veterans Administration patients.

QUESTION 20: What are the limitations on the dental treatment of veteran patients?

ANSWER: The following concerning dental treatment for veterans who are in-patients in Army hospitals has been coordinated with the interested divisions of the Office of The Surgeon General and the Veterans Administration. However, to date, it has not been published.

"Dental treatment for veterans who are in-patients in Army hospitals as beneficiaries of the Veterans Administration will be furnished on the request of chiefs of hospital services following determination of need by the chief of

dental service. This treatment will be the same as that furnished military personnel (see letter AG 703.1 (4-16-42) MO-S-M, 25 April 1942, Dental services during and for six months after war) except that patients will be held in the hospital for dental attendance only when it is for the treatment of Class I conditions other than the replacement of missing teeth. No outpatient dental treatment will be provided."

General Denit called the attention of the hospital commanders to the folder prepared for them. He spoke of an extract of questions and answers made of the conference of the Director of Service, Supply and Procurement Division, WDGS, 12 and 13 August 1946, which he believed contained a great deal of interesting information. The following is a question he wished to emphasize "Question: What recourse does the chief of technical services have when the maintenance and custodial services provided at Class II installations by army commanders are reported unsatisfactory by commanding officers of the Class II installations?

DISCUSSION:

Instances of this nature should be called to the attention of the appropriate War Department General Staff Division for initiation of corrective action. However, it is believed that the Class II installation commander should report any such deficiencies to the army commander before reporting such facts to The Surgeon General. Undoubtedly, most of the unsatisfactory conditions could be worked out by mutual arrangements between the installation commander and the army headquarters. Action should be taken as follows:

a. The installation commander should report the unsatisfactory conditions to the army commander and attempt to work out a satisfactory solution.

b. If corrective action is not forthcoming the installation commander should report the conditions to the Chief of technical service who in turn should attempt to work out a solution informally with the army commander.

c. If the above steps do not obtain results the chiefs of technical service should report the unsatisfactory conditions to the appropriate War Department General Staff division."

General Denit stated that he quoted that question because the matter had been discussed at the conference during the morning session. He stated further, that there were many other questions pertaining to Army commanders and commanders of Class II installations in the folder which are extremely valuable.

Colonel McGibony called the attention of the hospital commanders to the copy of The Bulletin of The Inspector General of the Army, the August issue of which carries a practical check list for inspection of hospitals. He stated that he had been informed by the Inspector General's Office that if there is anyone not on the distribution list, he may write to that office and be placed on the mailing list to receive the monthly issues of the Inspector General's Bulletin.

AR 210-20, published June of this year, provides for the establishment of a permanent installation planning board at those installations which have been either tentatively or finally selected and designated by the War Department as being installations planned for permanent or prolonged retention. The mission of these planning boards is two-fold: (1) the preparation of a comprehensive and continuing plan and program by which to achieve the orderly and systematic development and improvement of the installation as a facility for its intended purpose; and, (2), the submission of consolidated and properly supported construction and long-range repairs and utilities programs and supporting data to the War Department on which to base and fully defend military appropriation and authorization acts necessary to realize the objectives of the plans and program developed by the planning boards. At the present time, twelve general hospitals have been either finally or tentatively selected for retention. This means that plans and programs for each of these general hospitals should be included in the over-all master plans of the planning boards of the installations concerned. It, therefore, becomes incumbent upon the commanding officer of each of these general hospitals to develop long-range plans for construction and repairs and utilities programs for his particular hospital and to insure their inclusion in the installation master plan.

It would probably be helpful to clarify the relationships between the various field agencies in the repairs and utilities chain of responsibility, and the corresponding echelons in the chain of medical responsibility. The first point I wish to emphasize is that under WD Circular 138, 1946, an army commander is responsible for the accomplishment of all repairs and utilities work at all Class I and II installations within his army area. He, with the advice and assistance of his engineer, holds the post, camp, station, or other installation commanders responsible. The post engineer is a technical staff officer of the post commander, but in addition, exercises a command responsibility over the carrying out of all repairs and utilities functions at the post. At a Class I post which has on it a general hospital, - a Medical Department Class II installation- the post commander's responsibility for the accomplishment of necessary R & U work applies not only to the Class I part of his post, but to the general hospital as well. It is his job to allocate funds made available to him to carry out his responsibility, so as best to accomplish his mission. The charts I have shown you demonstrate that the general hospitals have not fared too badly. Unfortunately, however, occasions arise in which there is an honest difference of opinion as to whether the needs of the hospital are being met as well as are those of the rest of the post. Such differences are found to become more frequent as funds become less plentiful. In such cases, we should like to see the hospital commanders enlist the aid of the army surgeon in an attempt to correct the difficulty by agreement with the army engineer at army level. The armies have additional funds, and they have complete responsibility for repairs and

utilities at both Class I and Class II installations. It should be possible for nine out of ten such cases to be settled at army level before the Office of The Surgeon General or the Office of Chief of Engineers ever hears of them. Post commanders have authority to approve projects up to $1,000 within the funds made available quarterly. Such funds are usually allotted to posts on the basis of square feet of covered building space, acres of improved grounds, square yards of paving, and other such factual criteria. They should be sub-allotted to the Class I and Class II portions of the posts on the same basis, or as directed by the army commander. Projects over $1,000 must be forwarded to higher authority for technical review and approval. An army commander has approval authority up to $10,000; every project over $10,000 must be forwarded to the Chief of Engineers for approval.

In closing, I again repeat the mission of repairs and utilities is to provide a service coordinate with the mission of the installation concerned. Repairs and utilities, by maintaining to the maximum the higher maintenance standards already established at general hospitals, will do its part toward enabling the Medical Department to maintain the highest standards of hospitalization for the sick and wounded available anywhere.

DISCUSSION:

COLONEL REYER: There is a shortage of supplies and personnel to do repair work at William Beaumont General Hospital. The hospital looks terrible; it is terrible. We can't get such simple things as minor plumbing repairs or trash pickups. Maintenance projects started ten weeks ago are not completed. Is completion in sight? My post engineer is a nice fellow, when I can catch him--but he has four posts to handle and no help. We have two men to clean seven miles of corridors.

GENERAL BRAGDON: There is a shortage of critical materials and the Veterans Administration has top priority on all of them. A check should be made to see if the post engineer is doing everything in his power and going through channels. The post engineer can go to his regional engineer who in turn can go to the army engineer, and if he can't do anything, the post engineer should appeal to the Chief of Engineers. A lot of the difficulty is a question of money, and we don t control the money. You, as commanding officers, should make sure you are getting your full share from the post and the post commander should make sure that he is getting his full amount from the Army.

MR. VINCENZ, from the Office, Chief of Engineers: The Office of the Chief of Engineers has been advised of the conditions at Beaumont through Lt. Colonel Souder's office. A representative from the Office, Chief of Engineers was sent down to check on this almost a year ago. As a result of this investigation the post engineer was replaced. If the matter has still not been corrected it will be investigated again.

LT. COLONEL SOUDER: I suggest that the Office of The Chief of Engineers acquaint the post engineer with the proper procedure for getting assistance, in requisitioning supplies, etc. It appears that army engineers either do not know how effective their service is in locating scarce supply or else fail to avail themselves of it.

GENERAL BRAGDON: Perhaps the hospital commander is not receiving his full share of deferred maintenance.

CONFEREES: "How do we know if we are getting our share of deferred maintenance?"

GENERAL BRAGDON: You should go to the commanding officer of the post and inquire as to your share of deferred maintenance. The money for deferred maintenance is allocated according to square footage of the physical plant. General hospitals were the first installation that got money out of regular funds.

GENERAL BLISS: Most of the problems appear to arise in Class II installations on Class I posts. - General Bliss then called on General Hillman, Col. Streit, Col. Keeler, Col. Turnbull and finally General Beach. All except General Beach apparently experience the same problems.

GENERAL BRAGDON: That, in general, seems true, however, WD Circular 138 states that R & U for Class II installations is under the Army.

GENERAL HILLMAN: There seems to be a lack of enthusiasm to get things done, at the post level. When other means fail, I put in a call to The Surgeon General. He added that, generally, he was not complaining, but the difficulties at Letterman General Hospital seemed to have become more apparent since the Sixth Army took over.

COLONEL STREIT: I have to go through three headquarters before the maintenance people supposedly assigned to me can get off their chairs and go to work. I can't issue work orders to them. The situation is impossible.

COLONEL TURNBULL: I am unable to get supplies, especially of small things, for example, door knobs.

GENERAL BRAGDON: There is a ceiling on what you can have in storage for repairs and utilities.

COLONEL TURNBULL: I have used medical personnel to perform engineer duties + have difficulty in getting a statement of expenditures and I can't get it until a month after it is spent. I used local labor in painting the interior of the hospital.

COLONEL KEELER: At Madigan we have the same problem as Beaumont, only more of them.

GENERAL BRAGDON: I feel it would be beneficial if War Department would get out a regulation governing Class II installations on Class I posts. I will look into the matter and see if separate or sub-post engineer establishments for Class II hospitals on Class I posts are the answer. We shall propose them.

GENERAL BEACH: We have no serious trouble at the Army Medical Center. My post engineer is always on the job and is able to anticipate most problems before they become serious.

GENERAL BRAGDON: If my post commander were not giving me adequate engineer service I'd pound on his desk until he did. It is his responsibility.

COLONEL STREIT: The post engineer is several miles away from my buildings and I have no one to turn to for advice on engineer problems. The only way I can get them studied is to ask the engineer to come over after I have discovered the problems. The engineer personnel won't work unless a work order is issued from the post engineer and that takes considerable time inasmuch as the work order must go through channels.

GENERAL BRAGDON: It might be a solution if a deputy post engineer could be established, but with the loss of many engineers through separations, etc., line officers have been appointed post engineers in many instances.

COLONEL KEELER: Everything said thus far applies to Madigan, only, perhaps more so. The greatest difficulty at Madigan is to know how much money is allotted to the hospital. I find it particularly delaying to have to submi work orders through channels before the work can be accomplished. My maintenance is weeks behind and it has been necessary in order for my hospital to operate efficiently, to take Medical Department personnel off their duties of caring for the sick and use them for engineer duties.

GENERAL BLISS: What is the situation at Class II installations not on Class I posts?

GENERAL BEACH: I am having no difficulty.

GENERAL BRAGDON: I suggest three solutions to aid in this matter.

1. A deputy post engineer at the general hospital.

2. Have communicated to Class II installations, their proper share of the money which is allocated to armies.

3. Continued prodding from the Chief of Engineers to the post engineers to maintain their efficiency despite the loss in numbers of good personnel.

C. ARMY HOSPITAL SUPPLY PROGRAM.....Colonel Silas B. Hays, MC

Colonel Silas B. Hays, Chief of Supply, OSG, lead the discussion on methods of handling supply of nonstandard items, establishment of allowances and control of issue of equipment, and the hospital equipment modernization program. He made the following statements:

I have a very "blue" picture to paint. It has been blue enough in the last month or two. In the last few days it has become a great deal "bluer". You have heard something about the budget and the appropriation, and you will hear more again tomorrow. The situation regarding supply money is something like this. We have about $17,000,000 for supplies and equipment in the 1947 budget. That sounds like a lot of money. Back before the war when the Army was running around 150,000 troops we were always living on a hand-to-mouth basis and we had approximately $2,000,000 for supplies and equipment. The Army in 1947 is going to be ten times as big and our budget isn't ten times as large. Looking at it from another aspect, when the budget was computed we used certain troop figures that were prescribed, certain expectancy of hospital bed occupancy, and we estimated prices to be paid for supplies. All three of those figures have been wrong. Neither the Army nor the hospital bed occupancy have gone down to the figures used, and prices on all supplies have increased, which means that we will have to make the money that we had for supplies spread considerably. It may be that General Kirk will find it necessary to take money originally allotted for supplies and use it to pay civilian personnel. If a deficiency appropriation is to be looked upon favorably by the War Department, the Bureau of the Budget, and The President, it would still have to go to Congress, and Congress isn't scheduled to meet until next year. I don't see anyway that General Kirk can receive any assurance before next year that he will have any more money to spend than he now has. I wanted to start off my remarks by giving you that picture because it is very very "blue". It means that certainly for the next six months we are going to have to get along on the barest essentials. It means that the central purchasing office is going to have to buy only replacements and essentials. On local purchases hospitals will have to do likewise. I don't know whether we all realize or appreciate how much the cost of medical care has gone up. To give you an example, streptomycin this year is costing one and one-half million dollars. That is just one small item as compared to a two million dollar appropriation for all supplies and equipment back in the years before the war. Even to give a decent standard of medical care it costs more. It is the desire of General Kirk and everyone in the office to equip and supply army hospitals with the best that we can get and make our hospitals equal to or better than other Government hospitals, and the best civilian hospitals. Until the money picture

became so acute in the last few weeks we had hoped that we would be able to do a considerable amount of modernization of hospital equipment this year. We may still be able to do some, but we certainly are not going to be able to in the first six months of this fiscal year.

We plan to survey general hospitals and the large station hospitals this fall to determine what equipment is needed to bring them up to acceptable standards of equipment; and this year and next year do as much as we can to meet that need. The plan briefly is this: That a team will be established by The Surgeon General, the job of which will be to determine standards of certain items of equipment (I am not speaking of surgical instruments, but of heavier types of equipment, such as the bedside tables, built-in-stainless-steel cabinets, shelves, and things of that nature) to decide just what our standard will be. In determining that standard we will visit some of the best equipped civilian hospitals in the country. Then the team will go around to the various hospitals, and, working in conjunction with the commanding officers, determine what is needed and what the degree of urgency is. With our peacetime hospitals there are no two hospital plants the same. Each one is different. A considerable amount of this equipment is going to have to be tailor-made, particularly tables, shelving and similar items. After we determine our modernization requirements, the equipment we will be able to furnish will be entirely a question of money. We are preparing at the present time the 1948 budget. We are putting in several million dollars for modernization. Whether this program will get by the various hurdles we do not know but we will fight for it.

Beginning the first of July of this year we put into effect a new nonstandard allowance procedure. It has been in effect for about six weeks and I would like to have your comments on whether it is working satisfactorily and if not, what should be done to improve it, and also, a statement of your opinion as to whether the allowance you get is adequate or inadequate.

DISCUSSION:

COLONEL MITCHELL: I have a $1,575 quarterly allowance. My best figure would be about $8,000 to take care of that enormous amount of supplies required by plastic surgeons. This money is for sponge material, dressings, etc., for use in connection with skin grafting.

GENERAL KIRK: Isn't that too expensive? Why not use cotton waste? How much do you spend on it?

COLONEL MITCHELL: We have about twenty-four or twenty-five cases per month. Only one place produces it. I don't recall the name.

COLONEL STREIT: The plastic surgeon at Dibble did not like any of the standard suture material. He wanted a 5-0 and 3-0 which is not on the supply table. During my tour with him I bought over $15,000 worth of that material for him. It is very much finer and no doubt is better in the large number of sutures they use in stopping bleeding. They won't use nylon since it tends to untie. Let them have what they want until the money runs out.

GENERAL KIRK: We are $21,000,000 in the red. We must save a little on expenses and use more standard material. Standard material will work.

COLONEL HAYS: I am interested in two things. First, is the system satisfactory? What about the allowance - is it adequate or inadequate?

COLONEL KEELER: I would say that the system is all right. I am beginning to get delivery on things. I think the amount I have is sufficient, which is $7,000 per quarter.

COLONEL HAYS: Does anybody have any special problems? Do you need additional money for any particular item?

COLONEL REYER: There is one problem - EKG machines. On the battery machines the batteries leak and we don't always have them available. I don't know whether this has come up before. Batteries are generally expensive; especially ones made for these machines which do not leak. Otherwise, I think we get along at Beaumont. We have made some of our own instruments and things. I have a very handy man in the automobile maintenance school who does this work. He turns out some of the instruments required and designs them in accordance with the wishes of the surgeon. I might ask about these metal wheelchairs. When these fellows go home they take the chairs with them. Every amputee takes them home - he is entitled to them.

GENERAL BEACH: I have 150 wheelchairs on order; received fifteen by freight the other day.

COLONEL HAYS: The next thing I want to discuss is the supply system during this coming year. The basic War Department manual on station stock control is TM 38-220, which is undergoing revision at the present time. I haven't been able to secure too much information as to just how it will come out. However, it will be referred to us again before it is published, for our concurrence or comment. I can give you briefly what we have already proposed on the revision and I would like any comments that you have as to whether the proposed revision is satisfactory or whether there are any changes that you would like to have.

Basically, you are interested in where you get the supplies and what your allowance is. Our suggestion on the manual was that requisitions continue to go directly to the depot and not through army headquarters; that you be authorized to establish your own allowances for all items, with the exception of 150 to perhaps 250 costly items that will require approval of the Office of The Surgeon General. A replacement of one of those items will be a routine matter and would not come to this office. An increase of allowance would have to be referred to this office. Initially, we would ask you to submit your suggested allowance for this group of 150 to 250 items - as to what you think you need to run your hospital. In practically every instance you will already have these allowances on hand. In some instances you will not have them on hand. Your recommendations will be reviewed here, in conjunction with the professional consultants, particularly, and the allowances approved or revised. After the allowances have been established, should it become necessary to increase the authorization for one of the 150-250 items mentioned, application should be made to this office for an increased authorization. On all other items, both expendable and nonexpendable items (some 6,500 other items) it will be up to you to determine how many you need, the only control exercised being that of inspections that will be made from time to time by the Army and this office to determine whether or not you are accumulating equipment and supplies you do not have need for.

Question: Has it been found beneficial to keep on 60-day stock level rather than a 90-day level?

COLONEL HAYS: Twice within the last year we have gone to the War Department asking for increased stock levels from 60 to 90 days. Our request was turned down in both instances. If the hospital commanders feel that this matter is important enough we will go to the War Department again. Perhaps it would be advisable to ask for a 90-day level on certain items, only. Before we discuss this matter any further I would like to go back and get comments on the proposed authorization and supply system. Does anyone have any suggestions on that? I can't guarantee how it will come out, but unless you bring up something to change our minds, we will fight for what I have just told you.

If there are no comments, I would like to discuss 60 and 90-day levels. From my own standpoint, previously I felt much stronger about raising to a 90-day level than I have in the last few months. In talking to the various hospital supply officers I find that in most instances they find the 60-day level adequate.

COLONEL MURCHISON: We have had trouble at Percy Jones on some items such as ether and soap and have had to place emergency requisitions.

GENERAL KIRK: Does your supply officer go and see what is going on?

COLONEL HAYS: How long does it take to get supplies from St. Louis?

COLONEL MURCHISON: We have a very good service.

COLONEL TURNBULL: We have a lot of supplies we don't need. I have no storage space for them, and it is difficult to take care of these supplies. We have thousands of yards of gauze somebody has got to use in the next six months. If we don't use it, it will have to be declared surplus.

LT. COLONEL LOUIS F. WILLIAMS, Chief, Distribution Division, Office of Supply: The Second Army Commander has done an outstanding job of shifting supplies from one place to the other where they can be used. What the surgeon of the Second Army attempted to do was to redistribute that property within the Second Army Area to be utilized within that command.

COLONEL TURNBULL: There are enough supplies there to last for years. There should be some way of handling this property at Binghamton Medical Depot. We don't want to let it be turned in as salvage and then used as junk.

COLONEL HAYS: Naturally we have a great amount of excess property. The original Medical Department plan provided that when stations closed, the supplies and equipment would be returned to depots and there be declared surplus. However, about six months ago the War Department decided that all supplies and equipment now excess in posts, camps and stations would be declared surplus locally except those items that are still required by the War Department. We now publish a monthly list of required items which are to be returned to the depots. Everything over and above that which becomes excess at the station level is to be declared surplus by the station. This brings up the problem of transferring supplies and equipment from one hospital to another. Items not listed are carried in depots in sufficient quantity for eighteen months anticipated issue.

COLONEL TURNBULL: The point I wanted to make is that this property may be surplus to my needs but not to someone else's needs.

COLONEL HAYS: If it is not on that list it is to be declared surplus at the station level, because the Medical Department has adequate depot stocks and does not need the material.

COLONEL TURNBULL: I have a warehouse full of property. It has been there for over a year. Maybe some of that property may not be surplus now. When it is declared surplus there is nothing we can do about it. It is a lot of loss of property and somebody could use it if we had a place to keep it. It takes a lot of personnel to sort it out and store it.

COLONEL HAYS: What is it?

COLONEL TURNBULL: Oh! Everything. Electrocardiographs - we got some from England General Hospital. We got two or three basal metabolism machines. There is lack of coordination on much of this property. I have a smart supply officer. He took a truck and picked out what he wanted and brought it back to the hospital. Whatever we don't need someone else can use. I can't handle it because I don't have the space.

LT. COLONEL WILLIAMS: Return it to the Binghamton Depot.

COLONEL TURNBULL: Binghamton hasn't the room to handle it.

LT. COLONEL WILLIAMS: Yes, they have. All of our depots have space and will receive returns of those items required to meet our issue demands.

LT. COLONEL McGIBONY: Now about freezes. Sometimes before we can ship desirable property a freeze is put on the installation for the Veterans Administration. On other occasions when we know a freeze is imminent we ask commanding officers of hospitals to ship prior to our telling the War Department that the installation is surplus. This is done on the items which we need badly and commanding officers should ship such property promptly in order that it can be saved for use by the Army.

COLONEL ODOM: Equipment has been frozen at Mason recently. Prior to that time I had ordered dayroom furniture. It is beautiful chrome leather type furniture. I want to figure out some way not to let it get frozen

COLONEL HAYS: We are going to G-4 and try to get a clear-cut decision on that. We have got to watch out for the Medical Department. I would like to point out that the hospital commander is on the spot and we hope that he does let us know if any of this material really should be retained and given to some other hospital.

LT. COLONEL WILLIAMS: If you have a piece of equipment that you think should be saved and time does not permit reporting it to this office, then ship it to your distribution depot. In case you get a directive from this office to ship equipment, then freeze or not freeze, ship it and we will make explanation, if required.

COLONEL TURNBULL: Has Binghamton storage facilities to handle this equipment? If they have, why wouldn't it be sensible to ship all the property there and let them send it where it is needed.

LT. COLONEL WILLIAMS: There is no point in expending Government funds to needlessly transport surplus property. WD Circular 34, 1946 directs that it be declared surplus on the spot. We have one other thing. A lot of expensive nonstandard equipment. WD Circular 34 keeps us from getting reports on nonstandard items. If you have nonstandard items which in your opinion should be saved, report them to this office, if time permits - if not, ship them to the distribution depot.

COLONEL HAYS: I would like to bring up the question of medical supply officers in the hospitals. If you do not have as good a medical supply officer as you would like to have or think you should have, please let me know and I will do all I can to get you a better qualified man. We feel that the most likely place for the supply system to break is right in the hospital between the supply officer and the professional man. The supply officer may be prone to hold supplies on his shelves rather than get out and tell the professional man what he has. He should have them come down and take a look at the stock. It is no good on the shelves. Quite frequently when a complaint does come in about one thing or another, it boils down to the fact that the supply officer in the hospital is not doing his job. If you have supply officers with whom you are not satisfied, let me know while you are here. We will do what we can to replace them.

COLONEL STANLEY: My supply officer is ordered overseas. I have no replacement.

COLONEL GENTZKOW: The same thing applies at Valley Forge.

COLONEL HAYS: We will select a man for each place right away.

GENERAL KIRK: How many hospitals are washing gauze? I see by this show of hands that four hospitals are and the remainder are not. It is a good economy procedure. Everybody has a laundry. It is very simple to get it washed. Also, it is good occupational therapy for the patients. I think that on the supply business, if we are going to save money, we have got to save on these small things. I am satisfied that we can save fifty percent on adhesive, dressings, bandages, and gauze. Likewise, for these nonstandard supplies. Watch the little things carefully. Those are the things that cause us to run out of thousands of dollars. We had better become economy minded, but not where it interferes with patient care. There are so many little things where it can be stopped. Fifty percent of what we spend can be saved if supplies are properly dispensed. Instead of giving a patient a pint of medicine, give him two ounces. He isn't going to take but two or three doses.

Colonel Hays presented for discussion questions submitted by the hospital commanders:

Question 1: Is there any further information concerning the modernization of ward kitchens?

Answer : Standards have been set, requirements determined and "pilot" procurement initiated on equipment for ward diet kitchens including electric food carts, food cabinets, dish conveyors and several other items. It is now extremely doubtful whether any more than this pilot procurement can be accomplished prior to the next session of Congress, in January 1947. The 1947 medical budget is inadequate to support the Medical Department except on the barest necessities. Whether the War Department will approve the submission of, and Congress pass, a deficiency appropriation is very questionable at this time.

Question 2: Is the adoption of a standard War Department form possible for the use of all Medical Department installations for the purpose of requisitioning and purchasing nonstandard items, either from the depot or by local purchase, when required for the immediate use of patients to prevent suffering and distress?

Answer : This matter, as far as I know, has not been considered in this office. It sounds like an excellent suggestion. I would like to request the Commanding General of Percy Jones General Hospital to submit this suggestion in detail complete with sample forms and explanation of their use. If any other hospital commanders present have developed procedures and forms along this line, it is requested that they be submitted, also we can then have them tried out in other hospitals and if proved valuable, standardized as a new procedure.

Question 3: Is it possible to authorize named, permanent general hospitals a four month supply of fast-moving, expendable items?

Answer : Twice within the last year, this office has attempted to secure War Department approval for increasing the supply level from sixty to ninety days, both times without success. If the hospital commanders present feel that this is worth another try, this office will be glad to try it again. However for this third attempt, it will be necessary, I believe for us to secure substantiating data which the hospital commanders will have to furnish. It might be advisable, also, to restrict our request to those items which are really causing trouble. I would like to hear a discussion on this matter so that we can determine our course of action.

Question 4: Is the modernization of such items as bedside tables, dressing carriages, instrument cabinets, etc., planned for named general hospitals?

Answer : This question is answered in 1, above.

Question 5: Organization Chart TM 8-262, under "Supply Division", makes no mention of medical supply, which is a major supply function of the hospital. In the experience of the commanding officer, medical supply officers are usually much more competent officers than the quartermaster officers assigned to general hospitals. (Submitted by Commanding Officer, Army and Navy General Hospital.)

Answer : The organization chart in TM 8-262 is predicated, I believe, on the maintenance of a single supply stock record. I do not believe that many, if any, hospitals are operating with a single stock record. The organization chart in TM 8-262 shows a Quartermaster Branch and Signal Branch. I would like to hear how other hospital commanders have solved this problem. I assume that they have established a Medical Branch and probably in a hospital considered as a supply division itself with subsidiary branches. There is one point I would like to make and that is that where possible, it would appear advisable to make a Medical Department officer the director of supply.

Question 6: Why is Medical Department equipment shipped to this hospital upon deactivation of other stations without prior approval of this hospital? During recent weeks this hospital has received shipments of Medical Department property from various discontinued stations. In most instances these supplies are excess to our needs. When received at this station action must be taken to dispose of this excess, that is, either declare them surplus or ship them to the depot. There is no space available here for storage of excess equipment and supplies. Specific examples: Shipment from O'Reilly General Hospital, Springfield, Missouri, consisting of eight crates and boxes, total shipping weight 1293 pounds. Authority quoted on shipping document was: TWX SGD TSG USA Washington, 23 July 1946. However, this office did not receive a copy of this authority. This equipment was in excess of station requirements. Six or seven other such shipments have been received, consisting of three to 148 boxes. (Submitted by Commanding Officer, Army and Navy General Hospital.)

Answer : Due to the necessity for removing property as quickly as possible in order to avoid it being "frozen" for some other agency, arbitrary decision as to its transfer must frequently be made. In this instance all of the property shipped from O'Reilly General Hospital was expendable occupational therapy supplies which over a period of time would readily be used by the receiving station. It is not believed that any station is pressed for storage space. Almost all of them are contracting in size and unused wards and other buildings can be used for temporary storage. The increased stock can be retained by making temporary adjustments in station stock levels. This office has and will continue to inform receiving stations by means of copies of the shipping directive forwarded at the time it is furnished the shipping station.

Question 7: There is a need for replacement of victory type equipment with modern type equipment. Requisitions have been forwarded to general depots for many such replacements; items which they have not as yet been able to furnish. Information is desired as to how such equipment may be obtained in the near future. It is the understanding that The Surgeon General desires that the most modern equipment be made available for use in general hospitals. (Submitted by Commanding Officer, Pratt General Hospital.)

Answer : See answer to Question 1. The Surgeon General desires that the most modern equipment be made available for use in all permanent hospitals. However, present indications are that budgetary restrictions during this fiscal year will curtail this program markedly. Several months ago this office instituted the "Lions" Program which called for the replacement of all inferior items which could be made with standard and desirable type. Again this program was put into effect prior to the establishment of Pratt General Hospital. It is suggested that the Commanding Officer, Pratt General Hospital be instructed to submit a requisition direct to this office for such items as he needs in his installation. This office will ship all items available from Account 18 and give consideration to procurement of additional items.

Question 8: Is it the plan to dispense with old type wooden Balkan frames and replace them with a type of metal fracture frame such as are made by the DuPuy and other companies? The present Balkan frame is satisfactory and fulfills its purpose, but is unsightly in a modern General Hospital.

Answer : There is no plan at the moment for the replacement of the old type wooden Balkan frame with the metal fracture frame such as are made by the DuPuy and other companies. Both types of Balkan frames are functionally satisfactory but it is agreed that the wooden type frame is probably more unsightly than the metal one. During the recent war, the metal type frame was unavailable and the wooden type Balkan frame was, of necessity, procured. If it is the consensus of opinion of hospital commanders that the metal fracture frame is desirable, it will be considered for planning purposes to be implemented when stocks of existing wooden frames are exhausted or when the financial position of the Medical Department will allow such a change.

Question 9: There is a need at every general hospital for Stryker turning frames from time to time to be used in lieu of the standard Bradford. Advantages are that one person can turn a patient with ease whereas about four people and two Bradford frames are needed otherwise. Can these frames be included on the supply table?

Answer : Stryker turning frames were procured as nonstandard and furnished general hospitals and the majority of regional hospitals, however, this was prior to the establishment of Pratt General Hospital. Some of these frames are available in the St. Louis Medical Depot, having been turned in from hospitals which are closing. This office is instructing that depot to ship three of the frames and the cart for the frames to Pratt General Hospital.

Question 10: Stryker motor-driven cast cutters should be on the supply table. Present hand operated cutter costs $18.50 and is slow and tiresome to use. The Stryker cutter is safe, rapid and easy to operate. Cost $85.00 on the retail market.

Answer : The Stryker motor-driven cast cutter has recently been tested at Percy Jones General Hospital and Walter Reed General Hospital, the findings being that in its present state of development it is too light for the heavy duty required in army hospitals. This has been reported to the manfacturer whom, I understand, is now developing a heavier and more sturdy cutter.

D. PERSONNEL PROBLEMS IN ARMY HOSPITALS------Col. Francis P. Kintz

General Bliss opened the second morning's session of the conference and turned the meeting over to Colonel Francis P. Kintz, MC, Chief of Personnel, OSG, who acted as discussion chairman on the subject of personnel problems in Army hospitals. Colonel Kintz made the following statements:

The subject of this morning's conference is personnel problems in Army hospitals, including the use of Medical Department specialists and expert consultants, with pertinent data concerning the Central Officers' Assignment Group; the Army integration and Army interne programs; officer and enlisted personnel; nursing, dietetic and physical therapy personnel; civilian personnel; dental personnel; the performance of station complement functions at Class II hospitals, and the fiscal problems in Army hospitals, including availability of funds and proper charges against appropriated funds.

In the conduct of this part of the conference program Colonel Kintz made a few general remarks and then called on the various branch chiefs and consultants to explain in detail their various personnel activities. "As you well know, personnel is the life blood of any organization, it has its fingers into everything and it is a constant and continuing function and responsibility. It goes on all the time. No commanding officer can afford to turn over the assignment, the classification nor the utilization of his personnel to a junior officer, and then forget it." We have been most fortunate here in the Office of The Surgeon General in having a Surgeon General and Deputy Surgeon General who have been extremely personnel conscious, and I think that many of the advances that have been made by the Medical Department in the past few years have been the result of their personal interest in handling personnel matters. We are fully aware of the magnitude of the personnel problem in your hospitals. We are trying and will continue to try to be a Personnel Service in fact as well as in name, and will continue to give you all the assistance we possibly can to assist you with this problem. Since VJ-Day, with the rapid demobilization amounting to practically a disintegration, we have been so busy plugging holes that much advance planning has not been possible. The situation was too "fluid." We are now getting to a more stable situation and I feel quite sure that before long we will be able to plan assignments ahead of time and get orders out so that we will not be continually disrupting the domestic and official situation of an officer. We are continuing to get many requests for transfers for personal reasons. While we try to personalize as much as possible the requests for transfers for purely personal reasons, and for like reasons, it is obvious that many of these requests will have to be disapproved as they

materially increase the work in every office. We would like to have these requests discouraged unless they are really justified.

The Office of Personnel is set up with two divisions, military and civilian. The Military Personnel Division is further divided into several branches as: the Classification and Records Branch; Assignments Branch, Procurement; Separations and Reserve Branch; the MAC, WAC, and Enlisted Branch. There are also the Nursing Consultants Division, the Dietetic Consultants Division, and the Physical Therapists Consultants Division. These divisions, while not assigned to the Office of Personnel, are physically located near personnel and all activities and policies concerning personnel matters of these sections are coordinated by the Personnel Office.

As to the functions of the Office of Personnel, General Kirk has said that the office acts somewhat as the Adjutant General for The Surgeon General, in implementing and coordinating the recommendations for assignments of officers as recommended by the Dental, Veterinary, Surgical, Medical, Neuropsychiatric, and Preventive Medicine Consultants. As Colonel Freer puts it, he recommends to us and we act as the mouthpiece in accomplishing the recommendations.

I would like to speak a little here about refresher training. This will be discussed more fully by Training Division, but the Office of Personnel has to work so closely with training in the assignment of officers that it is not out of place here. Last August, it was decided that it was necessary to "reprofessionalize" the Regular Corps. Practically every man in the Regular Corps had been on administrative and staff assignments for the past five years, and if we were to avoid a professional vacuum, with the separation of the Reserve and AUS officers at hospitals, something had to be done to get the Regular Corps back on its feet professionally. A request was submitted to the War Department to have 100 individuals returned from the various theaters and placed in refresher training in order that they might become chiefs of services and sections. This program was accepted by the Regular Corps with such enthusiasm and became such a tremendous morale factor that it was allowed to expand and it did expand to the point where any officer returning from overseas who requested refresher training was placed in such training. We have had in refresher somewhere between 350 and 400 individuals. As Colonel Duke will tell you, the qualifications of these men vary from those who are practically board men to those who have had practically no professional work. We are now in the process of reassigning these individuals, getting them back on the job in station and general hospitals. We will continue to change the refresher-type program to the residency-type program which is laid down in AR 350-1010. It is not planned that the refresher-type program will be continued indefinitely as such. We receive frequent requests from

hospital commanders and personnel officers to assign permanently at a hospital officers in refresher training. While we would like to comply with all such requests we have to evaluate each assignment from the overall standpoint, and Colonel Freer and Colonel Cole, Medical and Surgical Consultants are constantly reviewing these people in refresher training. The mere fact that an officer has reported and is on refresher training does not mean that it is an absolute justification for him to be assigned to any installation if he is needed in his specialty somewhere else.

General Kirk and General Bliss in their opening statments called attention to WD Circular 229, 1946. This circular is the result of over a year of harrassing, driving, needling, cajoling, and personel effort on the part of General Kirk which resulted in the document as finally published. It is certainly a step forward and we should take full advantage of it and make it pay dividends. A regulation, AR 605-12, is coming out shortly, that revises Circular 229 and adds a very interesting paragraph that implements one thing which is not included in the circular. To date we have promoted or recommended promotion on a total of 242 individuals: forty-six from second to first lieutenant, one-hundred-forty-seven from first lieutenant to captain, and forty-eight from captain to major. These were approved by The Surgeon General's Promotion Board and forwarded to The Adjutant General. We have promoted one major to lieutenant colonel. This officer was a former prisoner-of war, who was due and eligible for a one grade promotion. On the recommendations as sent in, it is advisable that the man's correct MOS be shown. We had a recommendation come in, recently, with an MOS of 3100. In the write-up of the individual he was described as chief of surgery in the hospital to which he was assigned. He was a specialist and was doing specialist work. So, from a functional standpoint, the proper MOS should be included on each individual.

Concerning the ASTP students, we have taken in some 4,000 since April. Many have been processed and sent overseas after completing the training course at the Brooke Army Medical Center. Many have been assigned to hospitals. This is a most fertile source of Regular Army material. If properly assigned and properly handled these young men can be stimulated into coming in the Regular Corps. We would appreciate any information on the personality, ability, adaptability, etc., of these men.

The Central Officers Assignment Group is a part of the old office of G-1, War Department General Staff. Under the Simpson Board Reorganization of the War Department, G-1 became the Director of Personnel and Administration, WDGS. The Central Officers Assignment Group (COAG) is a part of that office. COAG consists of a chief, with a small Control Branch, and representatives of the various technical services and major commands. COAG is charged with the career planning of

officers and with the permanent change of station on all officers. As the representative of The Surgeon General with CO&G, we control or initiate all permanent change of station assignments on Medical Department officers. When this first came into effect, it was felt we might lose control of our personnel. Under this system The Surgeon General has not lost any of his prerogatives. The system seems to be functioning very well. The armies object to orders at War Department level, but think it is too soon for the system to be turned down without trial.

Colonel Cole and Colonel Freer will no doubt elaborate more fully on the specialist problem, however, certain factors which require considerable action on the part of the Personnel Service should be mentioned here. In December 1945, it was quite evident that at the rate of separation we would soon be without any qualified plastic or orthopedic surgeons, and there were still thousands of patients to be taken care of. Permission was obtained to freeze a maximum of one hundred, of which eighty-five or ninety officers were frozen by name, and a one grade promotion secured to compensate them in some way for their retention in the service. Last spring, we had to go to the War Department and get exemptions from demotion for these men who were about to be reduced in grade under the current demotion program. Demotion was deferred until 1 September 1946, and the need for these men was evaluated. We cannot release all of them. A certain number will have to be retained on active duty, and a certain number of them have received notices that they will be demoted. Information from G-1 is to the effect that these officers will not be demoted until 1 January 1947, as requested by this office.

With the ceiling imposed on the Office of The Surgeon General by the War Department Manpower Board, and the inability of the medical installations to live within the sub-ceilings imposed, it was decided that a survey of installations was indicated. Survey teams have now practically completed their work. Major Murray will give you some of the facts on this survey. This is about the best thing we have done recently. We now have some real ammunition for going to the War Department for an increase in ceiling. We feel that hospitals and this office have very definitely benefited from this survey. Some of the officers on the survey teams said they were most happy to be in on it because of the opportunity to visit other hospitals and see how they work.

Considerable discussion has come up in the office from time to time relative to resignations. I would like to read the policy given to the Secretary of War's Personnel Board by General Paul, Director of Personnel and Administration. I quote from memorandum for the President, Secretary of War's Personnel Board, subject: "Policy Concerning Acceptance of Resignation of Regular Army Officers:"

"1. It is desired that in considering an unconditional resignation submitted by a Regular Army officer, the Secretary of War's Personnel Board be guided by the following policy:

"a. For the duration of the emergency plus six months the unconditional resignation of a Regular Army officer will not be accepted unless:

"(1) The officer has completed a period of commissioned service equal to the period of total service which is required to make an officer of the same branch or arm of service eligible for relief from active duty under Readjustment Regulations, and

"(2) Full consideration is given the recommendations of the Commanding General of the Major Force or the Chief of the Service concerned.

"b. The resignation of an officer commissioned upon graduation from the United States Military Academy will not be accepted unless he has completed four years commissioned service.

"c. Notwithstanding the above provisions, the resignation of an officer submitted with evidence that the officer's military service is the cause of undue personal or family hardship will be reviewed by the Secretary of War's Personnel Board and will be accepted if the Board so recommends.

"d. The above policy will not be applied to resignations submitted in lieu of reclassification or trial by court martial.

"2. Copies of this memorandum are being forwarded to the Commanding Generals of the Major Forces and the Chiefs of the Services for their personel attention.

/s/ W. S. Paul
Major General, GSC
Director of Personnel
and Administration"

After World War I there were quite a few resignations. Through the Fiscal Year 1919 through 1926 the following totals were recorded:

1919	Medical Corps		28
1920	"	"	157
1921	"	"	49
1922	"	"	29
1923	"	"	29
		Total	302

The present strength of the Regular Army, Medical Corps is as follows:

Major Generals	1	Majors	333
Brigadier Generals	3	Captains	637
Colonels	246	1st Lieuts.	46
Lt. Colonels	33	Total 1299, Medical Corps officers	

Since VJ-Day the losses for the Medical Corps through resignation have amounted to: Ninety-three resignations submitted, of which thirty-six are pending, fifty-four have been approved and three have been disapproved. The average age of those resigning from the Medical Corps is thirty-three years. Seventy of these were in Regular Army refresher training; twenty-three were not. In the Dental Corps, eighteen have submitted resignations, ten are pending and eight have been approved. In the Veterinary Corps, only one resignation has been submitted and this one is pending. In the Pharmacy Corps, six resignations have been submitted, five are pending and one has been disapproved."

At this point Colonel Kintz turned the conference over to Colonel Freer who spoke for the Consultants Divisions of this office and Colonel Cole who answered the questions submitted to the Consultants by the hospital commanders.

1. The use of Medical Department specialists and expert consultants.

Colonel Arden Freer, MC, Chief, Medical Consultants Division, Office of The Surgeon General, discussed the use of Medical Department specialists and expert consultants. Colonel Freer made the following statements:

During World War II, The Surgeon General developed a system of utilizing professional consultants from which great benefit was derived. In order to insure the maintenance of the highest professional standards and to provide close liaison with leaders in the medical profession at large, this system will be continued and extended in the future. Professional consultants who are recognized experts in the medical and allied specialties will be designated by The Surgeon General.

As representatives of The Surgeon General the professional consultants are concerned essentially with the maintenance of the highest standards of medical practice. It is their function to evaluate, promote and improve further the quality of medical care and sanitation by every possible means, to advise in the formulation of the professional policies of The Surgeon General and to aid in the implementation of these policies.

Consultants are considered under three headings:

1. The headquarters group (SGO)
2. Army area consultants
3. Hospital teaching consultants

All are appointed by the Secretary of War upon recommendation of The Surgeon General.

The mission of the headquarters group is to perform special duty in the Office of The Surgeon General, or on trips from that office. That of the army area group is to visit any and all classes of hospitals in the zone of interior as was done during the war by the service command consultants. Names of these expert consultants will be furnished each army surgeon, who will arrange directly with the consultant for such hospital inspection trips as are deemed advisable and submit vouchers to the Office of The Surgeon General for payment upon completion of the mission. Reports of inspection will be submitted through technical channels.

Hospital teaching consultants in medicine and surgery will be provided for all permanent general hospitals and three AAF hospitals. Consultants in additional specialties will be provided for certain general hospitals in which special residencies are approved, such as pediatrics, dermatology, urology, neuropsychiatry, and physical medicine. These consultants are to further in every possible way the educational program for the advancement of medical officers in the specialties and assist in maintaining the highest standards on the professional services of the installations to which they are assigned. They are to be regarded as members of the professional staff. Commanding officers will arrange with them schedules which are mutually convenient. Additional details in this connection are to be found in letters from the Office of The Surgeon General, subject: "Civilian Expert Consultants" and "Expert Consultant Service and Travel."

Inquiries have been received from some of the hospitals which are scheduled to close this year relative to assignment of consultants to those installations. Requests have been received, also, to have them assigned to some dispensaries. The funds allotted by the War Department for these consultants were approved on the basis of training,

and the training program, in this respect, is planned only for the permanent general and regional station hospitals. The question has been raised, also, as to whether army consultants are to visit hospitals to which local teaching consultants are assigned. While there will be less need for visits by army area consultants in such hospitals, there will be occasions when these visits will be indicated and proper.

It is to be noted that nothing in this program changes the provisions of AR 40-505 which authorized the use of consultants for individual military patients at public expense whenever and wherever indicated.

References on the subject of consultants are: AR 350-1010; AR 40-505; WD Circular 101, 1946 and letters, Office of The Surgeon General, subjects: "Civilian Expert Consultants" and "Expert Consultant Service and Travel."

At the conclusion of his remarks Colonel Freer called on the various Directors of the Consultants Divisions.

Colonel Caldwell, MC, Director of the Neuropsychiatric Consultants Division, stated that there was one thing that was not exactly clear and that was the convalescent annex and the use of such an annex. Patients with a neurosis, who do not require additional psychiatric therapy on a general hospital level, should be sent immediately to the convalescent annex where their treatment, given in conjunction with the convalescent program, will be supervised by a neuropsychiatrist. It is considered that the best treatment for the neurotic patient is not in a hospital. The general consensus of opinion in the Army is that this type of patient should be treated on a convalescent level, and in uniform. This treatment is being outlined and will be published in a War Department circular.

Lt. Colonel Strickland, MC, Director of the Physical Medicine Consultants Division, prefaced his remarks by quoting a saying of Elbert Hubbard, "A person is usually down on that on which he is not up on." Particularly is this true of any individual branch of medicine. Still there is much vague conception and some misconception about the consultants in physical medicine. This office is engaged presently in obtaining the services of specialists in physical medicine for utilization in the consultant's program. The services of these individuals will be made available to all general hospitals. The use of medical officers who have had specialty training in physical medicine has not been properly handled. Certain of the ASTP doctors who were sent out to general hospitals after a short course of training in physical medicine were not assigned to physical medicine divisions and utilized to the best advantage. It is realized that these young doctors are not

"cured" specialists, but they are much better than a medical officer whose interest lies in some other field. There must be a doctor between an orthopedic surgeon and the female physical therapist, who is not trained in certain aspects of diagnosis and treatment. It must be remembered that, although of the greatest value, the female physical therapist is not a doctor. The use of the physical medicine consultants who will be made available should be to come into the hospital, survey the physical therapy department, take the individual officer assigned to the service, and make him more able by training him and working with him a certain number of days each month.

In physical medicine there is not an American Specialty Board, although reliable sources have indicated that in all probability an American Board will be established in February. There are over 650 doctors in this country who are specialized in the field of physical medicine, and there are two large societies for physicians who are interested in specializing in this field. Many of the consultants in physical who are being appointed are heads of departments in medical schools and are very competent to teach and to carry out the program which will be inaugurated.

DISCUSSION:

COLONEL McMURDO: At Oliver General Hospital we don't have a board member in urology and I have taken our teaching consultant and have had him operate once a week until all urologic cases could be cleared up. He works up his cases during the week and operates them on Friday. This procedure has worked out very satisfactorily.

GENERAL QUADE: Are funds ample for the use of consultants?

MR. UPHOFF: I think the funds are ample, unless we exceed the total number of consultants. We have asked for 318 consultants and have enough money to cover these.

GENERAL HILLMAN: The letters which came out from the Office of The Surgeon General spoke of using the consultants three days a week. Of course, many consultants can't give three days a week.

COLONEL FREER: Of course, this is a new thing with us. Generally speaking, however, it was thought that the need for consultants would vary with the patient load and the size of the installation. We thought if we would provide three or four names acceptable to you it would be possible for you to have a man present a couple of times a week. This is not absolutely rigid. Some weeks you may need a consultant only one day, and other weeks you may have a need for him three or four times. We must profit by experience as we go along.

COLONEL BECK; We are just starting the use of consultants, but it becomes increasingly plain to me that unless you have at least three men you are not going to get the work done.

COLONEL FREER: I have been asked, "Why not provide six or seven consultants?" Well, matters of economy must be considered, and so there are limitations on the number of consultants who can be engaged. Eventually the total number of consultants appearing on the roster will be cut.

COLONEL REYER: I have only one consultant in medicine and none in surgery at William Beaumont General Hospital.

COLONEL FREER: Some hospitals are not conveniently located to civilian medical centers and the availability of consultants is limited.

COLONEL COLE: We have been trying to get consultants for Beaumont. The field there is very limited, and the same is true of some of the other hospitals. Percy Jones is another general hospital where it is difficult to get consultants because of the location of the hospital. Now, here is something I should like to bring up. The teaching consultants are furnished to your hospitals only for those subjects which the hospitals have been designated to teach. We get requests for X-ray men from hospitals in which a course in X-ray therapy has not been established. There has been a little misunderstanding on the part of some of the hospital commanders that all hospitals should be teaching institutions in all subjects. Economy measures prevent such a system, and so we are setting up consultants for those subjects in which the hospital has been designated as a teaching institution. If you need a consultant on a special case you can always get him under AR 40-505.

COLONEL STREIT: How many hours a day must a consultant be at the hospital in order to draw his forty dollars?

COLONEL FREER: The Veterans Administration decided very wisely, I believe, that the situation would vary at times. If a consultant goes to a hospital for an hour or two, thereby interrupting his schedule and upsetting his plans, he may be paid the usual per diem of forty dollars, for the regulations state, "For a day or any part of a day." A close watch will have to be kept, however, to see that one consultant doesn't consistently receive $40.00 for an hour's work while another consultant works consistently a full day.

COLONEL STREIT: There is one consultant at Brooke who is receiving twenty-five dollars a day while the other consultants are receiving forty dollars a day.

MR. UPHOFF: I think that was in the case of Dr. Page and that has now been cleared up. All consultants are now paid forty dollars a day.

COLONEL MITCHELL: One of the consultants at McCornack General Hospital received a letter stating that his appointment was for ninety days. Must he be reappointed after each ninety days?

MR. UPHOFF: There must be some mistake in that case, inasmuch as all letters appointing consultants state that the appointment is for a period of one year, with the restriction that the consultant cannot be paid for time in excess of ninety days. Some consultants have been previously appointed for five days or for ninety days, or for similar periods, but that was not under the present program. If you have to use a consultant in excess of ninety days, you must make special request to the Secretary of War. Consultants have to be appointed each year.

COLONEL MITCHELL: Can a consultant be used before notification of the consultant's appointment has been received. From the time the papers are sent to the Civilian Personnel Division and notification of appointment received at least ninety days will elapse.

MR. UPHOFF: A consultant should not be used until he is officially appointed.

COLONEL COLE: There is one other thing on the pay situation, and that is the case of the man who has been retired for physical disability by the Army and is being paid a retirement stipend. Such an individual cannot be paid the forty dollars a day, but can receive only that amount which will bring him to the maximum limit of the Government pay he is permitted to receive on his retired salary.

GENERAL KIRK: There is something I would like to say about the convalescent facility for psychoneurotics and the question of physical medicine. All doctors are interested in things other than those two. It took a year and a half to get the convalescent program going during the war, but it paid great dividends — almost as much as did surgery in the line. Please get your shoulders behind these two things. The greatest improvement made during the war was in the handling of the psychoneurotics, and in physical medicine, which now comprises physical therapy, occupational therapy and reconditioning. It is the general opinion that twenty to twenty-five percent of patients referred to physical medicine do not require physical therapy. Give them occupational therapy. Please back these two younger agencies of medicine. An outstanding job was done during the war, so do not neglect these considerations.

COLONEL UPSHUR: There is only one consultant, a surgical consultant, appointed thus far at Army and Navy General Hospital. There is a scarcity of consultants in Hot Springs, Arkansas.

COLONEL FREER: There are some consultants on the way to Hot Springs.

2. DISCUSSIONS by branch chiefs, Office of Personnel.

Colonel Kintz called on the various branch chiefs of the Office of Personnel for discussion, starting with Mr. Uphoff, Chief of the Civilian Personnel Division.

Mr. Uphoff urged that hospital commanders give as much attention to the training and welfare of civilian employees as to the military employees. In civilian personnel administration be just as careful in making assignments as you are with military personnel. Civilian personnel is more of a problem and you should give more time to development of this personnel. Money is short and you will have to make one person do the work of two and do it better. We do have money for training civilian personnel and you should take advantage of it.

Colonel Leech, MC, Chief of the Classification and Records Branch, Office of Personnel, called attention to a draft of the new active duty card which will be used for all Medical Department officers. This card was developed after considerable study of cards that were used in the past, and is considered as complete, up-to-date, and modern a record that it is possible to obtain. It is felt that with the use of this card it will be possible to have an accurate and current record of each Medical Department officer, which will make up in part for our not being able to interview and evaluate each officer personally. The Office of Personnel is in the process of transferring information contained on the old cards, the 66-1, and the 178-2 to these new cards.

In regard to the professional training evaluation form, Colonel Leech requested that this form be turned in on each officer at the end of each ninety-day period of refresher training. The Professional Training Committee is dependent to a great degree on the information contained in this report. In some cases it has been necessary to hold up an officer's assignment because the information as to the progress of his training was not forthcoming. Colonel Leech requested that the American Specialty Boards not be contacted in all cases, but that the educational committee of the hospital survey the officer's qualifications and send an evaluation of his status to the boards, when it is considered that the officer is within a year of obtaining his certificate. Colonel Leech requested, further, that information concerning the patient load and type of patients be provided and that a statement be made as to the adequacy of the clinical material for support of the training program.

In regard to the overseas roster, Colonel Leech stated that there is in the Classification Branch, Office of The Surgeon General a roster containing all of the Regular Army, Category I, and volunteer officers listed as follows:

(1) Volunteers
(2) Officers with no overseas service
(3) Officers with less than six months overseas service
(4) Officers with less than a year's overseas service

In choosing an officer for overseas assignments, officers having no overseas service are chosen first. It is the intent of COAG that as many of these officers as possible be sent overseas. The date which is used as a basis for overseas service is 7 December 1941. In regard to the classification of officers, Colonel Leech stated that the MOS of an officer can be found in TM 12-406, which outlines the procedure of classification in detail. Officers should be evaluated constantly. The Technical Manual states there should be a re-evaluation of an officer in March of each year, however, re-evaluation should be done whenever it is considered necessary. The Office of Personnel is dependent on subordinate headquarters for keeping the MOS of each officer up-to-date.

Lt. Colonel C. B. Perkins, Chief, Military Personnel Division discussed the deferments of officers and, for the information of the hospital commanders, stated that The Surgeon General is definitely committed to meet all overseas theater requisitions for personnel, and, to date, has done so. However, the question of deferments for so-called "key personnel" has become increasingly important, and as a result the following policy has been established in regard to the deferment of officers:

(1) Officers will be alerted as early as possible.

(2) Replacements will be furnished when asked for, but officers alerted will not be deferred pending arrival of replacements.

(3) All officers who have not had overseas service or who have had a comparatively short tour of overseas service should have understudies who can take over on short notice.

(4) Closing hospitals will be provided a replacement in the same MOS as the officer alerted, with a minimum overlap of two weeks, when requested.

(5) The final decision as to essentiality will rest with The Surgeon General.

(6) Key personnel who have had no overseas service or who have had less than six months overseas service in World War II, and for whom replacements are needed, may be requested in a special letter requisition, Attention: MEDCM-A.

Colonel Leech added here that volunteers have a number one priority for overseas service. The reason these officers do not go just when they desire is because they are "choosy" about the theater of assignment.

Lt. Colonel Ida Danielson of the Nursing Personnel Branch, OSG, stated that the War Department was in the process of recalling one thousand nurses to active duty. Already 600 letters have been sent out to nurses from the Office of The Surgeon General. Nurses with dependents, married nurses, limited service nurses are not being accepted. Those nurses who are recalled are asked to sign a Category I or a Category VIII statement. Overseas duty will still be on a volunteer basis provided the nurses are physically qualified. It is anticipated that there will be no integration of nurses this year inasmuch as the Bill for the female corps has not yet been passed. The new Bill provides for 2500 Regular Army nurses. The maximum age limit for integration will be thirty-four years, except for a few nurses over thirty-four years of age with special MOS's, such as anesthetists and nurses with NP-training. Chief nurses are being asked to review the MOS of their nurses in order to bring the nurse classifications up-to-date. The European Theater of Operations wants at least forty anesthetists. Promotions from grade of second to first lieutenant are still being made of nurses who have been in the grade of second lieutenant for eighteen months or more, provided they merit promotion.

Major Helen C. Burns of the Dietetic Consultants Division, OSG, asked that the hospital commanders urge the qualified dietitians in their hospitals who are eligible for release to change to Category I or to one of the new categories. Most of the dietitians are now realizing that the Army has something to offer and are anxious to continue on duty if their services are needed.

Captain Olena H. Cole of the Physical Therapists Consultants Division, OSG, asked that the hospital commanders make every effort to keep their hospitals covered with qualified physical therapists. A number of physical therapists are changing their categories to I and II and are being assigned to hospitals. Where there are several physical therapists assigned to a hospital, it is best that the senior physical therapist, who is an experienced individual, supervise the work of the

physical therapists in the various clinics. Rotation of physical therapists from the small clinics to the large clinics, so that the personnel will get well-rounded training, is advisable. At the present time an attempt is being made to set up a civilian position for a physical therapy aide that is on the order of the nurse's aide. This will fill a great need.

Captain Beatrice I. Ringgold, MAC, WAC Personnel Officer of the Military Personnel Division, stated that, numerically speaking, the situation concerning the WAC's in the general hospitals was not good. There are, at present, 3100 WAC's in general hospitals. By 30 September 1946 there will be approximately 1353 remaining. Many WAC's are anxious to get out of the Army in order to take advantage of the G.I. Bill of Rights, because their future in the Army is uncertain. Most of those volunteering to stay in want to go overseas. Unfortunately, there is no requisition for WAC medical technicians to serve in overseas areas except in Panama. In order to give them an opportunity to serve overseas, a clerk's school has been established at Camp Lee, Virginia. Upon successful completion of this school, the personnel will qualify as clerk-typists. All those with military occupational specialties other than 405 or 213 may have the opportunity to attend that school. Those with critical MOS's will be applying. Basically, that is not sound, but if non-volunteers wish to attend the school specifically for the purpose of going overseas as typists, they may do so and thus be saved for service in the Army. The first class starts on 2 September 1946. A quota has been given to hospitals on the East Coast. This was due to the short amount of time in which we had to fill our requisition. The West Coast will be taken care of later.

As far as WAC officers are concerned, it is strongly recommended that, if they are worthy, they be detailed in the Medical Administrative Corps in order to be held for the Medical Department.

The latest on the wearing of civilian clothes is that Colonel Boyce, Director of the WAC, has requested permission for WAC's to wear civilian clothes. The wearing of civilian clothes during off-duty hours would be a good morale factor for the WAC's.

DISCUSSION:

COLONEL MITCHELL: Will there be any WAC replacements after 1 September 1946?

CAPTAIN RINGGOLD: Right now, it is very hard to tell, because the enlisted women who have not already volunteered have until 31 October to decide to stay in or to be separated from the Army. We can only promise to do the very best we can for you.

COLONEL TURNBULL: What about specialized WAC's and those who are technicians?

CAPTAIN RINGGOLD: If the WAC's with critical MOS's, according to WD Circular 105, 1946, have volunteered to stay on duty after 31 October, they are not eligible to attend the clerks' school. They are eligible, however, for direct assignments overseas provided we get requisitions for their MOS's. Panama has sent in a requisition for medical technicians.

GENERAL HILLMAN: What procedure do you use in detailing a WAC officer in the MAC?

CAPTAIN RINGGOLD: A WAC who desires to be so detailed should write a letter to the Office of The Surgeon General through channels. If you approve her request, we will do so.

Major Bernard Aabel, MAC, discussed the Medical Administrative Corps officer situation. Major Aabel stated that out of a total of 22,500 MAC officers on duty during World War II, there are now approximately 3,500 on duty, Army-wide. Procurement authority has been obtained for recall of about 1,000 officers. Up until 23 August three hundred MAC officers had been recalled. Campaign applications have been sent by direct mail to officers whose 201 files have been carefully scrutinized. A ten percent response has been obtained.

An attempt to establish a three months officer candidate school was turned down by the War Department because of the new ruling of nine-months for officer candidate courses. Overseas theaters have been able to appoint MAC officers direct and the Pacific Area has recommended and appointed one hundred such officers. Of the 492 Pharmacy Corps officers integrated, approximately 125 were from civilian life.

The criteria for separation of MAC officers is to be lowered to twenty-four months as soon as possible. If there are some MAC officers who have not been overseas or who have had less than six months of overseas service, they can be expected to be ordered overseas in the very near future. The 82nd Airborne Division is greatly in need of MAC officers for glider and parachute training. As to clinical psychologists, when the separation criteria is dropped to twenty-four months there will be a very acute shortage. We are trying to get specialist MAC officers out of small hospitals and especially Sanitary Corps officers who are needed in the larger installations. Also, we are trying to get phychologists out of assignments other than psychology work. These officers are needed at disciplinary barracks and larger camps. MAC's on other than Medical Department duties are being screened for possible transfer to Medical Department duties, for which the need is much greater.

Colonel Armstrong, MC, of the Office of Personnel was called upon. Colonel Armstrong made the following statements: "Personnel should be decentralized." Colonel Kintz has stated that personnel are the "lifeblood of any organization." I heartily agree with both these statements. Regardless of how adequate the supplies and how fine the equipment, medical service cannot be rendered except with adequate personnel, especially medical officers. We cannot in this office personalize our entire personnel system; we must have your help. I recall an officer, whom I have known for over forty-years, who reported at one of his early stations with a fair basic training in general surgery. This was known to the commanding officer, who, in spite of it, rather gleefully told him that he would have the laboratory for about two weeks, after which he would be permanently assigned in medical supply. All of you have had a similar experience, furthermore, you probably think that this situation was obsolescent. Gentlemen, it is not! One of our young ASTP officers with a twenty-seven month residency in surgery reported to one of your executive officers and was assigned to dispensary duty in spite of his protests, without any explanation for the malassignment. General Kirk earlier made the statement that we have to get one thousand Regular Army officers from the ASTP group. Gentlemen, unless you personally sell the Army to these young men we will be lucky if we get fifty from the entire group. I cannot emphasize too strongly our desire that you personally interview each young officer who reports to you for duty and that you contact him again periodically, making every endeavor to see that he is properly assigned and given every opportunity to develop a sincere interest in entering the Regular Army. Unless this is done, the future of the entire Medical Department is threatened.

DISCUSSION:

Lt. Colonel C. B. Perkins, MC, Chief of the Military Personnel Division, OSG, presented for discussion the questions on personnel submitted by the hospital commanders:

Question 1: How are position vacancies to be determined in units not covered by an approved table of organization and when allotments are not made by grade and arm or service (see Par 4, WD Cir 229, 1946)? (Submitted by: CO, Fitzsimons General Hospital.)

Answer : There has been no definite policy determined as to position vacancies in units not covered by approved tables of organization. However, in the past it has been the policy that field grade officers should hold the positions of chiefs of service, chiefs of section, and assistant chiefs of section when the individual hospital has been designated as a center for a specific specialty. For example, if a hospital has been designated as an orthopedic center the

chief of service, chief of section and one or two assistant chiefs of section, who are qualified, have been promoted to the grade of major or higher due to the responsibilities which they are carrying.

Question 2: Paragraph 6c, WD Circular 229, provides for promotion of certain specialists to grade of major after twelve months service and includes certain MOS's for Sanitary Corps. Are first lieutenants, Sanitary Corps holding such MOS's eligible for promotion to Captain after twelve months service? (Submitted by: CO, Fitzsimons General Hospital.)

Answer : First lieutenants in the Sanitary Corps holding such MOS's as outlined in paragraph 6c, WD Circular 229, do not come under the provisions of this circular. It applies to Medical Corps officers only. The circular is being amended to this effect.

Question 3: Are officers otherwise qualified, eligible for promotion if sick in hospital with possibility of appearance before retiring board eventual disposition (see Par. 7h, WD Cir 229, 1946)? (Submitted by: CO, Fitzsimons General Hospital.)

Answer : If an officer is not expected to serve a reasonable length of time, normally six months after his promotion, he should not be promoted but receive his promotion at the time of separation.

Question 4: What is meant by a "manning table position" as used in paragraph 6c, WD Circular 229, 1946? (Submitted by: CO, Fitzsimons General Hospital.)

Answer : The "manning table position" has not been definitely defined. The manning table is a guide as to whether or not an officer is performing duties commensurate with the grade and responsibilities of a major. To a large extent this should be left up to the judgment of the commanding officer. This was done probably so that we could increase the number of field grade officers working in our general hospitals.

Question 5: Is it necessary to use a consultant a minimum amount of time even though his services are not necessarily required? For example, the services of a pediatrician are not necessarily required at this general hospital at this particular time. Would it be possible to maintain the consultant on the approved list and through local agreement, use his services when they are required? (Submitted by: CO, Fitzsimons General Hospital.)

Answer : It is not necessary to use a consultant a minimum amount of time unless his services are actually required. This does not prevent the consultant from remaining on the approved list and being available for call when and if his services are required.

Question 6: Some confusion has been caused, particularly as regards personnel matters, over the apparent lack of a clearly defined line of demarcation over jurisdiction of the army and the technical services at Class II installations. Can functions be more clearly defined in directives? Example: SG Circular 3, cs, states specifically that no critical officer specialist will be released from the service without first sending a TWX to the SGO for concurrence. Ltr, Hq Seventh Army, file AJMPD 210.3 dtd 12 July 1946, subject: "Criteria for Separation of Medical Department Officers," was addressed to CO's, Class I, II, and III installations within the Third Army Area and did not indicate in any way that prior concurrence of the SGO was necessary or even desirable in any case. Since the letter from Hq Seventh Army quoted a TWX from TAG it caused considerable confusion. It is believed that such confusion would be avoided if separation directives on Medical Department personnel were transmitted to general hospitals by the SGO only, quoting appropriate TWX's from TAG. (Submitted by: CO, Pratt General Hospital.)

Answer : There are two Service Units at each Class II (general hospital) installation:

a. Technical Service Units, the personnel of which is directly under the control of the Office of The Surgeon General. This includes all personnel assigned to Technical Service Units, both military and civilian.

b. Army Service Unit, the personnel of which provides the housekeeping services. This personnel, although under the administration and supervision of the commanding officer of the Class II installation, is still army personnel. Requisitions and replacements for this type of personnel should be handled through army channels.

Question 7: What is the plan for supplying highly trained specialists, such as the following, to general hospitals where now these specialists are not available? Electro-encephalograph Technician (564), Medical Equipment Maintenance Technician (22) (Submitted by: CO, Pratt General Hospital.)

Answer : The plan for supplying highly trained specialists in such MOS's, as Electro-encephalograph Technician (564) and Medical Equipment Maintenance Technician (22), is already in operation. There is a school at the present time at Brooke to train Electro-encephalograph Technicians (564) and a school at St. Louis, Missouri to train medical equipment maintenance technicians (22). Also, the other technical specialists are being trained at the Medical Department Enlisted Technicians Schools. It is true, at the present time, that the great portion of the graduates of these schools are being used as overseas replacements, but a certain number are being diverted to zone of interior installations.

Question 8: Do we plan on having internes in army general hospitals? (Submitted by: CO, Mayo General Hospital.)

Answer : It is planned to have internes in army general hospitals commencing 1 July 1947.

Question 9: To what extent do we contemplate using civilian personnel in the future? (Submitted by: CO, Mayo General Hospital)

Answer : At the present time, there are three survey teams in the Office of The Surgeon General, which are making a survey of all named general hospitals. Part of their study includes a discussion of what positions in an army hospital can be satisfactorily filled by qualified civilians and the minimum number of military personnel required to operate the hospital in conjunction with the use of civilians. A definite answer on this subject cannot be given at the present time.

Question 10: Will enlisted personnel be trained and occupy key positions as in the pre-war period? (Submitted by: CO, Mayo General Hospital.)

Answer : Yes.

Question 11: In the majority of cases, when Medical Department officers holding key positions are ordered for duty elsewhere, no response is made to letters requesting their replacement. As a result the commanding officer is left in the dark and additional letters, TWX's, and phone calls have to be made. It is suggested that the Personnel Section, at the time such officers are detached, notify the Commanding Officer as to when he may expect replacement. To quote an example:

The anesthesiologist at this hospital, whose services are highly important, was due for separation on 3 August 1946, after voluntarily remaining on duty for two months beyond the due date. In spite of letters, TWX's, and phone calls, we are yet in the dark as to a replacement and have been without the services of an anesthesiologist for the past ten days. At the same time, the operative program must go on without an experienced officer. (Submitted by: CO, Army and Navy General Hospital.)

Answer : This office concurs in the remarks as outlined in this paragraph, and in the future will endeavor to replace key personnel prior to the departure of that personnel from the home station, and if this is impossible, which it will be at times, to keep the commanding officer informed as to the current developments in obtaining replacements.

Question 12: We would like to be informed as to The Surgeon General's policy for assigning officers to foreign service. Some have made requests to go and have been retained, while others who have no desire for foreign service are so assigned. At present our medical supply officer, a highly competent man, is alerted for foreign service. He is 57 years of age and completes 30 years service in 17 months, including enlisted service. Arriving as his replacement is an officer, age 28, anxious for overseas duty. (Submitted by: CO, Army and Navy General Hospital.)

Answer : It is the policy of this office to send overseas, first, officers who volunteer for overseas service. The second group which we are sending overseas is made up of officers who have had no overseas duty since 1 September 1940. The third group is made up of officers who have been overseas during the war but only for a relatively short period of time, that is, for periods less than a year.

Question 13: Personnel Problem: In allocating Medical Department civilian personnel it should be remembered that a hospital functions seven days a week, twenty-four hours a day. In some instances it costs the government more money to pay overtime than it would to hire additional personnel. (Submitted by: CO, Army and Navy General Hospital.)

Answer : Because this office realizes the difficulty that our general hospitals are experiencing in an attempt to operate under the present circumstances which exist in the field, The

Surgeon General has designated three survey teams to visit all named general hospitals and render a report as to the number of personnel, as to the number type, grade ratings, etc., needed to operate these hospitals. This whole problem is now under exhaustive study because it is realized that the War Department figures based on the manning guide charts are not satisfactory to operate hospitals in peacetime.

E. DENTAL PERSONNEL IN ARMY HOSPITALS----------

Brigadier General Thomas L. Smith

Brigadier General Thomas L. Smith, Chief of the Dental Consultants Division, OSG, discussed problems in regard to dental personnel in army hospitals.

General Smith stated that it is often hard to fill requisitions for dental officers when a specific MOS is asked for, as 3171, 3175, etc., due to the fact that usually the requisition asks for officers in company grade. Younger officers do not have enough experience to be classed as specialists, so it may be necessary to send in officers in the higher grades. In the recent integration of officers in the Regular Army approximately forty-three were integrated in the grade of major, however, nearly all the officers being procured through Selective Service and the ones transferred from the Navy are young officers, and many lack experience.

DISCUSSION:

General Smith then discussed questions pertaining to dental personnel that had been submitted by the hospital commanders.

Question 1: The system of classifying dental personnel does not seem to be comprehensive. Many dental laboratory technicians are not strictly to be classified as 067, yet can do some laboratory work. It is suggested that the classification designation, Dental Laboratory Technician (067) be broken down into various classes according to the degree of proficiency. As a suggestion, a man - 067A - could meet the requirements of TM 12-427; 067B - could be plaster of paris manipulator; 067C - Bridgework; 067D - Finisher, etc. Would such a system be feasible? It is believed it would help greatly in requisitioning personnel. (Submitted by CO, Pratt General Hospital.)

DISCUSSION: The system of classifying dental personnel does not seem to be comprehensive. Many dental laboratory technicians are not strictly to be classified as 067, yet can do some laboratory work. It is suggested that the classification designation Dental Laboratory Technician (067) be broken down into the various classes according to the degree of proficiency. As a suggestion, a man (067A) could meet the requirements of TM 12-427, (067B) could be a plaster of paris manipulator, etc.

Answer : Classification of enlisted Dental Laboratory Technicians (067) in the classes of A, B, C, D, E, etc., is a very practical suggestion. Civil Service has just completed, and had approved, new specifications for civilian dental laboratory mechanics, from SP-3 to SP-8, inclusive, depending upon the training and experience of the technician. A system of classifying enlisted technicians could be worked out in a similar manner. In fact, it would be very desirable, and an effort will be made to have this done, both as an aid in requisitioning personnel and as a guide to establishing appropriate ratings for the more experienced technicians.

Question 2: When may general hospitals expect to receive more experienced and better qualified dental personnel? (Submitted by CO, Percy Jones General Hospital.)

Discussion: With more cases requiring extensive treatment, it becomes increasingly important to have more experienced dental personnel in general hospitals. At this station, the operation of three clinics and the care of maxillo-facial patients with but one qualified oral surgeon, makes the assignment of two more semi-trained oral surgeons essential. The same problem exists in the prosthetic section. Replacements to date have been youngsters, recently graduated and requiring the supervision of older men. Although qualified personnel have been requisitioned, uncertainty as to their arrival makes planning difficult.

Answer : It is very difficult for us to meet the requirements for officers in the specialized branches of dentistry. We are at this time in the process of releasing our older men who have had experience in prosthesis and oral surgery, and replacing them with younger ASTP officers who have not had the opportunity nor time to gain experience in this line. So it appears that this situation will become even worse. Every effort is made in this office to portion this type of personnel on an equitable basis to the stations as needed. The more capable and promising younger officers will have to be put on the job and trained to handle these responsibilities. One suggestion might be offered in this respect, however. When requisitions are submitted for officers of the specialized MOS numbers, it is suggested that they be placed in the higher grades rather than in the company grades with the idea of promoting them if they are qualified. This is ordinarily the premises for which they have gained their promotion, and no doubt are older better qualified officers. The younger company grade officers have neither had the time nor the association to gain such qualifications.

F. PERFORMANCE OF STATION COMPLEMENT FUNCTIONS AT CLASS II INSTALLATIONS.....Major R. Murray, Jr.

Major Russell Murray, Jr., MAC, Chief of Personnel Authorization Unit, OSG, discussed the following problems pertaining to the subject of the performance of station complement functions at Class II hospitals:

Problem 1: Clarification of responsibility for certain activities shown in WD Circular 138 as amended by Circular 170, 1946.

DISCUSSION:

There appears to be many circumstances which have caused army commanders to interpret the reorganization directives in such a manner and to direct hospital commanders to consider activities as the responsibility of The Surgeon General and vice versa. Our office has in some cases been appraised of such facts.

Our personnel survey teams have attempted to indicate in the survey reports, the exact disposition of controversial activities.

The War Department General Staff may not agree on certain of these interpretations and as personnel authorizations and allocation of funds are channeled through either The Surgeon General or the army commanders by the War Department General Staff on its interpretation of the directives it is vitally important that correct allocation and assignment of all personnel be made. We believe the survey teams have the correct interpretations.

Action: Such matters which remain controversial should be referred to the attention of The Surgeon General for appropriate action.

Problem 2: Personnel authorizations made by army commanders to hospital commanders for the performance of station complement activities.

DISCUSSION:

The problem arising from the recent personnel authorizations must be considered in the over-all as one which is likely to remain constant until the Postwar period planned strength has been reached by Army and the then remaining allotments have been fairly and equally apportioned to all the major commands and in turn to each installation.

The review of the personnel problem must take into consideration the terrific drop in the size of the Army in the past year and the fact

that many missions which were being performed by troop units and field forces became the continuing responsibility of the chiefs of the technical services simply because the personnel in troop units no longer existed. Confusion and delay in administrative actions occasioned by the reorganization of the War Department have added further problems to the matter of adequate distribution of available personnel, plus the fact that Congress cut the budget estimates for pay of personnel and then further directed absorption of the fourteen percent pay increase in the appropriated funds.

To be specific in talking personnel authorizations to you hospital commanders, I feel I should tell you some of the circumstances which caused the present situation, which I feel is definitely a wrong condition from your standpoint and from that of The Surgeon General.

In February 1946, the War Department Manpower Board called upon The Surgeon General to furnish his final estimate of operating personnel requirements for 30 June 1946 for Class II medical installations. This was computed and based upon the best knowledge then available. No estimate for general hospitals was made as it was not known that general hospitals would be a part of the requirement.

The allotment for personnel was received about 10 June 1946. In the meantime the War Department directed the transfer of the general hospitals from the administrative supervision of the service commands to The Surgeon General. Prior to this time your personnel authorizations came from one source, the service commands. The provisions of ASF Circulars 265 and 312, 1945, immediately effected the allotment of personnel to the general hospitals. These circulars outlined administrative responsibilities of the chiefs of technical services and of service commanders at Class II installations.

Just prior to the effective date of transfer of the general hospitals, Headquarters, ASF, was faced with the responsibility of determining how much of the 31 May and 30 June 1946 personnel authorization (which was to have been made to the various service commands) should be made to The Surgeon General and to the nine service commands, to cover the responsibilities outlined in ASF Circular 265 and 312, 1945. This had to be made in the face of an imposed reduction in the over-all hospital personnel authorization made by the War Department Manpower Board, acting in accordance with general instructions to reduce the military establishment.

On 11 June 1946, ASF ceased to exist as a part of the War Department organization, and it has been impossible to actually see the details of what part of the authorizations made on the ASF breakout

were allocated to army commands for general hospitals up to 31 May 1946. This office did not know how many overhead people were in the general hospitals. However, since then our office has been appraised of certain facts which are as follows:

a. War Department Manpower Board states that staff divisions must assume that the allocation by ASF was adequate for 31 May and 30 June 1946.

b. War Department Manpower Board states that the over-all authorization for general hospitals for 30 June 1946 was arrived at by determining that 69.4 people per 100 authorized beds was adequate personnel for The Surgeon General and army commanders.

c. War Department Manpower Board indicated 57.3 people per 100 authorized beds was the allocation for the over-all responsibility of The Surgeon General.

d. Certain armies have not authorized sufficient personnel for some hospitals to continue to operate the essential army activities.

e. One army disputes the allotment made in May 1946 to The Surgeon General and has requested this office to transfer approximately 1400 vacancies in personnel authorizations to that command.

f. On 31 May 1946, the general hospitals were required to discontinue reporting all personnel to service commands and on that date make two separate strength reports: one to the service command, on service command personnel, and the other to The Surgeon General, for personnel now under the jurisdiction of The Surgeon General. This new departure in reporting procedure, as usual, resulted in enough confusion to result in a two-week delay against the deadline of the reporting date.

g. The next month with the reorganization on 11 June 1946, another change in reporting procedure was directed by the War Department. Now everyone had to report army personnel to the Army headquarters in one report and all Surgeon General personnel on another report form to the Army headquarters, and send a duplicate copy of this report to The Surgeon General. This last change for reports, as of 30 June 1946, just about threw the "monkey wrench" at what was left of any system we had in operation. About twenty-five percent of the duplicate copies reached us. The Central Statistics Office, War Department General Staff, receiving the combined reports from the armies, couldn't furnish us with any satisfactory strength records. I state the above so that you may realize what kind of obstacles we were faced with. Strength reports to us furnish the basis of shifts in authorizations that must be made, indicate facts as to whether sufficient allotments exist and provide

data for necessary action. On 15 July 1946, we still weren't sure if the 31 May 1946 authorization was adequate.

Action: In view of continued pressure from many hospital commanders to furnish more authorizations for people we determined there was only one course of action left open. That was to conduct a careful personnel survey by the best hospital personnel officers who might be available. Eight hospitals were called upon to furnish the best officer in the hospital for the purpose. This office selected four qualified individuals, and, with twelve select officers and civilians available and in this office, less than five days after the action was decided upon, four teams consisting of three officers or civilians were formed, given a concentrated orientation and instruction, and started on the surveys.

Results of ten surveys have been tabulated, and, going back to the data we obtained from the War Department Manpower Board, I think you will be interested in this preliminary study and comparison. It is not final and must not be considered as such. Upon completion of and review of the surveys necessary action should be initiated by The Surgeon General to:

a. Obtain the necessary adjustment in personnel ceilings from the War Department Manpower Board based upon the findings of the survey, both for Technical Service Units and Army Service Units at general hospitals.

b. Wherever necessary advise the hospital commanders to assign personnel performing army commander responsibilities, but carried as strength of the TSU and paid for by The Surgeon General's funds, to the Army Service Unit where they properly belong.

c. Make proper authorization if available from higher command to each hospital.

d. Attempt to increase the ratio of military authorizations to civilian if this policy is approved by higher authority, thereby eliminating expenditures of appropriated funds which are presently insufficient.

e. Utilize the surveys to assist in preparation of new manning guides which now should be made in two parts for general hospitals. Part I for Surgeon General personnel and a somewhat similar tabulated basis as the WD Circular 209, 1944. Part II for army commander personnel in general hospitals. This is essential for the War Department Manpower Board which must make the over-all allocation, and for The Surgeon General, the army commander, and the hospital commanders, in order to properly make allocations of authorizations and estimates of future requirements.

Problem 3: Availability of appropriate type of personnel, both as to the individual and as to the particular category of authorization, as: MC, DC, ANC, EM, etc., and civilians, in certain areas not close to heavily populated cities and towns.

DISCUSSION:

Changing conditions, such as discharge criteria, severe cuts in appropriations, and lack of trained or qualified personnel, all have a bearing on this problem, plus the fact that since the war the individual desire to "put out" has disappeared. Other personnel, such as prisoners-of-war, volunteers, Gray Ladies, etc., have ceased to be available in large numbers. The cut from forty-eight hours to the forty-four or forty-hour-work-week, and elimination of overtime, add to the difficulties.

Action: These factors are all known to effect the efficiency of operation, and, until it becomes possible to convince the "top side", all the way to Congress, that these factors seriously effect our situation, no relief appears probable. It takes the most capable leadership to overcome this critical handicap.

I should like to explain that requests for increase in personnel authorization which may be favorably acted upon by The Surgeon General's Personnel Authorization Board, do not insure the assignment of the individuals. Requests for assignment of personnel to fill existing vacancies or to fill newly created vacancies should be initiated by the hospital commander to the Military Personnel Division, OSG.

DISCUSSION:

COLONEL TURNBULL: I have had three survey teams at Tilton General Hospital within two weeks: One from the War Manpower Board and two others, but the team that came from the Office of The Surgeon General remained for six days and really made a study. They knew what they wanted and knew what they were doing. The other teams stayed about fifteen minutes each.

MAJOR MURRAY: In instructing the survey teams we worked on two things for the teams to study in the hospitals. The surveys were started on 27 and 29 July, and, as a target, the reports were to be in this office by 22 August, so that by1September we would be able to go to the War Department Manpower Board with our installations personnel requirement for the 31 December allotment. There is a deadline on this of 3 September.

COLONEL MITCHELL: I called on the team for custodial personnel and it recommended an increase from thirty-three to sixty-seven percent for this installation.

COLONEL BERLE: Has any attempt been made to combine all the personnel in general hospitals instead of dividing it up into two categories?

GENERAL BLISS: This is covered in Circulars 138 and 170. The Engineers and their personnel are under the jurisdiction of army commanders, and the question is do we want this personnel under The Surgeon General?

COLONEL BERLE: At the time of the visit of the survey team there was some doubt as to whether the photostatic laboratory or the clinical laboratory were a part of the TSU or ASU. Has there been anything done about this?

LT. COLONEL McGIBONY: Hospital Division is trying to keep this laboratory and a change has been recommended to Circular 138 on that.

HOSPITAL COMMANDER: At the present time, at installations, the post engineer is to take care of custodial service. I find that, generally, the janitors furnished by post engineers are less competent than the people the commanding officer hires to do upkeep on the wards.

GENERAL DEVIT: Custodial services and housekeeping activities have been delegated to the Chief of Engineers, and if these are not satisfactory they should be reported to the army surgeon. It is not a matter of the numbers involved; it is a matter of the service provided -- is it satisfactory? If it is not satisfactory, the commanding officer of the hospital should not concern himself with the numbers of personnel involved, but with the type of service he is getting. If the service is not adequate, it should be taken up with the army commanders, and if no action is taken at that level the matter should be taken up with the Chief of Engineers.

COLONEL HALL: The chief difficulty is that the Engineer has no supervisory activity over this personnel.

COLONEL TURNBULL: What about the internal security?

MAJOR MURRAY: If guards are to perform internal security that is a responsibility of The Surgeon General, military police and guardhouse activities are charged to the army commander.

COLONEL HALL: Under a new directive the Fourth Army has taken thirty military police out of the Bruns General Hospital area. This eliminated

thereafter the necessity of patrolling Santa Fe. We had two or three riots, cuttings, etc., and now have been furnishing operating enlisted men out of the hospital TSU to patrol in the town.

GENERAL KIRK: An official report on this matter should be sent to this office. We will take it up with the proper authorities.

COLONEL MITCHELL: I have a great number of prisoners at McCornack General Hospital, both general and garrison, and we have been trying for months to get personnel to take care of them.

G. FISCAL PROBLEMS IN ARMY HOSPITAL, INCLUDING AVAILABILITY OF FUNDS AND PROPER CHARGES AGAINST APPROPRIATED FUNDS.....Mr. N. Fogelberg

Mr. Neptune Fogelberg, Chief of Fiscal Division, OSG, made the following statements:

Congress appropriated $68,000,000 for the operation of the Medical Department during Fiscal Year 1947. According to a review of fund requirements just completed, this appropriation is short approximately $27,000,000 for financing Medical Department activities required during Fiscal Year 1947. Of this shortage, approximately $10,000,000 applies to the operation of general hospitals, approximately $8,000,000 applies to the operation of station and regional hospitals, dispensaries, and other Medical Department professional installations, and the balance applies to the procurement, training, and research programs. The shortage of funds is occasioned by three factors over which the Medical Department has had no control:

a. At the time the budgetary estimates were prepared, it was anticipated that the total strength of the Army would be down to 1,550,000 by 1 July 1946. The actual strength of the Army on that date was approximately 1,890,000. This represents an increase of approximately twenty percent more than was planned for. The average military strength for Fiscal Year 1947 now appears to be 117 percent of the average used in the computation of the budgetary estimates. The revised distribution of the military strength has also adversely affected fund requirements of hospitals in the zone of interior. It now appears that the average military strength in the zone of interior for Fiscal Year 1947 will be approximately 141 percent of the average military strength used in the computation of the budgetary estimates. This added military strength means more patients and consequently more Medical Department civilian personnel than was planned for.

b. Congress in passing the Federal Employees Pay Act of 1946 made no provision for the extra funds required to increase pay rates by fourteen percent. Congress stated that the increased rates of pay must be absorbed within available appropriations and that it would not entertain a deficiency appropriation as a result of the increased pay rates. The greater patient load and the absorption of the fourteen percent increase has a double barrel effect on the shortage of funds since the Medical Department is required to pay terminal leave at a higher rate for civilians released during Fiscal Year 1947, a portion of which would have been released during Fiscal Year 1946 if the strength of the Army had reached the original objective.

c. The average cost of items to be procured during Fiscal Year 1947 has increased fifteen percent above the figure used in the computation of the budgetary estimates.

What is to be done about this shortage of funds? Three alternatives present themselves;

a. Obtain a deficiency appropriation. The Medical Department has submitted revised estimates to the budget officer of the War Department which will serve as a basis for a deficiency appropriation. This estimate must first receive the approval of the War Department; second, of the Bureau of the Budget; and third, the approval of the President before it will be carried to the Congress for action. In view of the President's determined effort to balance the Federal budget and to require the War Department to not only live within its appropriation for Fiscal Year 1947 but to effect a savings in addition, there is considerable doubt as to what relief might be expected in the form of a deficiency appropriation even if it should be approved by the War Department.

b. Change the proportionate relationship of military and Medical Department civilian employees utilized in the hospital system. At the present time fifty-six percent of the total Medical Department personnel utilized in general hospitals are military personnel and forty-four percent are Medical Department civilian personnel. If this ratio was changed, effective 1 October 1946 to eighty percent military personnel and twenty percent civilian personnel, sufficient funds would be available under the appropriation to finance the general hospitals. A similar change in the ratio of military and civilian personnel would have to be made in the case of station and regional hospitals, dispensaries, laboratories, and the like. General Kirk plans to carry the need for changing this relationship to the Secretary of War.

c. The only other alternative would be to release civilian personnel which would prevent the Medical Department from providing care for the sick and wounded. As of 30 June 1946, there were approximately 17,000 Medical Department civilian employees engaged in the hospital system in the zone of interior. This number would have to be reduced to approximately 5,000 by 30 June 1947 in order to stay within available funds.

In view of the serious financial condition of the Medical Department, it is imperative that expenditures be kept to the absolute minimum. Accordingly, the following suggestions are made:

a. No additional activity contemplating the expenditure of funds should be initiated without first ascertaining from the fiscal

officer that funds are available. The fiscal officer is prohibited by law from over-obligating his available funds.

b. Every effort should be made to review charges made against the Medical Department appropriation which are properly chargeable to some other War Department appropriation. It is not only illegal to make such charges against the Medical Department appropriation, but in addition the commanding officers of the hospitals are cutting their own throats in permitting such charges to be made.

DISCUSSION:

Mr. Fogelberg discussed the questions pertaining to fiscal matters submitted by hospital commanders.

Question 1: Will funds under project 611 (Research and Development be allotted directly from The Surgeon General's Office? (Submitted by CO, Percy Jones General Hospital.)

Answer : It is the understanding of the Fiscal Division that the only research and development activities at the Percy Jones General Hospital are those in connection with the prosthetic program and that no personnel are involved. Accordingly, personnel funds can be eliminated. With respect to requirements for supplies, requisitions for such supplies will be submitted to the Office of The Surgeon General. The action to be taken will consist either of supply of the item or the making of funds available to the hospital by the St. Louis Medical Depot for local purchase.

Question 2: What action can be expected on the allotment of funds first quarter FY 1947 under 2170805, project 414-01, Operation of Hospital Center, General Hospital and Convalescent, which funds are $18,817.31 short of required funds for first quarter? (Submitted by CO, Murphy General Hospital.)

Answer : Funds for the pay of civilian personnel under project 414-01 for September will be made available prior to 1 September.

Question 3: Does The Surgeon General have a standing operating procedure for requesting funds? If so, when will instructions be issued to Class II installations fiscal officers? (Submitted by CO, Army-Navy General Hospital.)

Answer : There is no standing operating procedure covering the request for funds in force at the present time. The fiscal officers of each installation are expected to request funds in advance of their actual requirements with justification and necessary supporting information. These requests will be made in letter form.

Question 4: How can a reconciliation of expenditures be made by fiscal officers on temporary duty travel allotments? Par 5, WD Circular 183, 1946, states that travel performed "by means of transportation requests, the four cents per mile estimated obligations will be considered firm, and will be shown as an expenditure." In this respect, your attention is invited to the fact that transportation request payments (made by Finance Officer, US Army, Washington, DC) are not shown as individual expenditures on Army Regional Accounting Office Register of Net Expenditures and it will hardly be possible for a station to distinguish specific payments and adjust fiscal records accordingly. (Submitted by CO, Army-Navy General Hospital.)

Answer : No absolute reconciliation can be made of expenditures as reported on the Register of Net Expenditures and the detail expenditure record of any installation with respect to expenditures made for temporary duty travel. This situation is recognized by the Chief of Finance, and instructions are included in WD Circular 183, 1946, to the effect that travel by commercial carrier will be established as an expenditure at the same time as obligated, at the rate of four cents for each mile of travel.

Question 5: Are Class II installation fiscal officers authorized to request funds from the Chief of Chaplains under Project No. 447 (Chaplain Activities), for the purchase of necessary religious supplies and equipment? (Submitted by CO, Army-Navy General Hospital.)

Answer : Purchase of necessary religious supplies and equipment other than wafers will not be made locally except in unusual circumstances. In connection with the supply of chapel equipment, attention is invited to the provisions of WD Circular 159, 1946, together with the following circulars which are in the hands of the local chaplains only: OFC of Chaplains, Circular Letter No. 304, 1 January 1946, "Addenda"; OFC of Chaplains, Circular Letter No. 311, 1 August 1946, "Addenda"; OFC of Chaplains Circular, 22 August 1945, subject, "Equipment and Supplies for

Chapels and Chaplains"; Addenda C. O. No. 304, which is an extract of Section VII, WD Circular 383, 1945, subject, "Non-appropriated Funds." Information has been secured from the Office of the Chief of Chaplains to the effect that it is desired that all worn and dilapidated chapel equipment be replaced. Requisitions should be submitted to the Quartermaster Depot, Alexandria, Virginia, through the New Cumberland General Depot at New Cumberland, Pennsylvania. Requests for funds for local purchase should be submitted directly to the Office of the Chief of Chaplains, War Department, Washington 25, D. C. where such requests will be scrutinized. If such requests are approved, funds will be made available directly by that office to the hospital concerned by means of a WD AGO Form 14-114, subject, "Obligation Authority."

Question 6: Are funds available under Project No. 510 (Equipment supplies, and other expenses for training), for the purchase of supplies and equipment for use of patients in training under the supervision of Occupational Therapist at general hospitals - such as radio repair kits, tools, small motors, etc. (Submitted by CO, Army-Navy General Hospital.)

Answer : No funds are available under project 510 for the purchase of supplies and equipment for use of patients in training under the reconditioning program. Supplies and equipments for such activities are listed in Medical Supply Catalog under Class F.

Question 7: Will funds continue to be allotted by SGO on a quarterly basis for the balance of the fiscal year? Some consideration has been paid to the possibility of yearly allotments. (Submitted by CO, McCornack General Hospital.)

Answer : Funds will not be allotted by The Surgeon General for requirements in excess of one quarter with the possibility that it might become necessary to allot for smaller periods. The restriction by quarter is placed on the Medical Department by the budget officer for the War Department and the Bureau of the Budget.

Question 8: If quarterly allotments are to be continued, will a procedure be set up whereby budget estimates are submitted quarterly, or does the teletyping of obligations through 15 August constitute a means of judging both what is needed for the balance of the current quarter and what will be needed for next quarter? (Submitted by CO, McCornack General Hospital.)

Answer : Quarterly budget estimates are acceptable if submitted in letter form, together with supporting information and justification. The obligations furnished as of 15 August constituted a one-time requirement only.

Question 9: Should requests for additional funds as needed be submitted in letter form or on the old NSC Form 100? (Submitted by CO, McCornack General Hospital.)

Answer : Request for additional funds can be submitted in the form of letters, radios, teletypes, or telephone conversations, depending upon the urgency. There is no requirement for using NSC Form 100 (Ninth Service Command Form.)

The Fiscal Division, Office of The Surgeon General is anxious to be of all possible assistance to the commanding officers of the general hospitals in working out their fiscal problems. Please do not hesitate to call upon us. Thank you.

H. TRAINING ACTIVITIES AT ARMY HOSPITALS.....Colonel R. E. Duke

Brigadier General Denit introduced Colonel Raymond E. Duke, MC, Chief of Education and Training Division, OSG, who discussed the professional graduate training program, including interim refresher training, interne training, and the residency training programs. Colonel Duke made the following statements:

In discussing the subject of Medical Department training, I would like to give you first the details of our present refresher professional graduate training program; second to give you the details of the plan for our permanent postwar residency program, and show you how we will progress from our present refresher training into the permanent residency program. Then, I would like, just briefly, to show you the details of the plan for our postwar Medical Department school system, and to show you where the residency program fits into that system.

As Colonel Kintz pointed out this morning, during the years of World War II, of necessity almost one hundred percent of the personnel in the Regular Army - Medical Corps officers - were assigned to staff, command and administrative positions. At the close of the war, and anticipating a rapid demobilization, it was evident that we had to get these Regular Army officers back into professional work. A Professional Training Committee was appointed here in the Office of The Surgeon General and about one year ago this program was begun. As officers were returned from overseas and could be relieved from their administrative or command assignments, they were placed in the general hospitals for professional training. Insofar as possible, and it was usually possible, they were given a choice of the specialty in which they wished to be trained. At that time AR 350-1010, "Professional Graduate Education for Medical Corps" was written and approved by the War Department. Likewise, SGO Circular 17, 1946, on The Surgeon General's policy of assignment was written, and also, WD Circular 101, 1946, which governs the consultants' program. Somewhere between 370 and 380 officers have taken part or are taking part in the refresher training program. About ninety officers have been sent to civilian institutions for training. Different courses varying from three weeks up to six months in length have been set up. Educational committees were established in the general hospitals to assist the commanding officers and the Office of The Surgeon General in the evaluation of these officers in training and in selecting those who should be sent to civilian institutions. Some of these committees have functioned very very well; I am sorry to say that others have not. We would like for the educational committee to consider each one of these officers individually and to evaluate him in detail. What I have in mind is this. Occasionally we have an officer

who will apply through channels for a course in a civilian institution. We feel that the educational committee should consider the officer in training very carefully: What he has been doing, what the caliber of his work is, and what the estimate of his capacity for proceeding on to Board certification is. Such an indorsement should be put on the letter to the Office of The Surgeon General. A letter often times is received from an officer who has applied for or requested a course, and the only indorsement on the letter is, "approved," signed by the hospital commander. That does not help The Surgeon General's Professional Training Committee very much in evaluating the officer, nor in determining whether or not he should be sent to the civilian institution.

In order that the training an officer receives counts towards his specialty board, and to raise the general standard of our training, the Teaching Consultants' Program was begun and is now in operation. In order to qualify the officers, especially those who were close to their board examinations, we have established review courses in the basic sciences. For the time being, these are being given in civilian medical schools. We have four such courses in operation now; we hope to have five in the very near future. These four courses are given, at the present time: at George Washington for Walter Reed; at Colorado University for Fitzsimons; at the University of California, for most of the Letterman group, and at the University of Washington in Seattle for the group at Madigan General Hospital.

The time has now come when it is becoming increasingly necessary to take officers out of the professional training program and give them assignments. We have lost our large group of AUS officers and the Medical Corps of the Army is more and more consisting of regular officers and ASTP graduates. These are the younger individuals who have just graduated from medical schools. So, as the office of Personnel needs officers for key positions such as chiefs or assistant chiefs of services and sections, and similar assignments, these officers must be pulled out. However, if the assignment is in a general hospital or large station hospital, the man is still considered to be in training. We want the educational committee at the hospital to continue to consider him so, and to continue sending in quarterly reports on the individual. One other thing I would like to point out. In some instances officers in the refresher training program have been assigned quarters on the post and they get the idea that they will continue in training at that particular hospital, or that permanent assignment will be to that hospital. This is not necessarily true. These officers may be moved elsewhere for a permanent assignment.

This training, I feel, has been all the way from excellent to poor. At some of the hospitals the officers have received a great deal of training. In other hospitals, and on some of the services,

it has only been fair, and in some instances it has been poor. There are many reasons for this. In some instances there has been an AUS officer who is chief of service and who has not been interested in training Army officers, especially, since he may be only a major and the student a colonel. I think the training has been largely in direct proportion to the interest and enthusiasm shown by the chiefs of service and the educational committee.

From here I would like to go into the permanent residency program. While the refresher training program has been in progress this last year, there has been in the process of formulation a permanent residency program for the general hopsitals. Now this permanent structure is almost complete, as you will se on this chart (inclosure No. 14).

We are establishing permanent internships and residencies in eight of the general hospitals. Also, we are attempting to establish residencies in internal medicine and general surgery at the eight larger station hospitals. This has not as yet been accomplished. To obtain approval of residencies we have to ask the American Medical Association to have their Council on Medical Education and Hospitals inspect the hospitals with regard to each residency. Their report goes to each of the fifteen American Specialty Boards for approval. It then goes back to the AMA which gives the final approval or disapproval. Our Personnel Division is attempting to get individuals assigned to the residencies over and above the ceiling needed to operate the hospitals. We are now attempting to get this approved by the War Department.

On the chart the red dots indicate those residencies where we have permanent approval by the AMA and the American Specialty Board. You will notice we have internships approved in eight of the general hospitals. We will get our first internes July 1st of next year. As it was pointed out this morning, we have authorization for one hundred internes as reserve officers, but we don't know as yet how many will be accepted for next year. You will notice, likewise, that we have approval for mixed residencies in these eight general hospitals to cover six months on medicine, and six months on surgery. The blue dots denote temporary approval. The AMA Board has given us temporary approval pending a final inspection. The black dots indicate those residencies which the AMA has recommended to the specialty boards for approval. However, final approval is awaiting the action of each of the respective specialty boards.

Not all of the hospitals have been inspected. Brooke has been inspected but we haven't received the final report. Madigan has been inspected, but likewise we have not received the report. Oliver and Percy Jones have been inspected, and we have the recommendations. Walter Reed will be inspected 26 August.

We will gradually progress from our present refresher program training into the permanent program. You will receive in two or three weeks the details of the program for mixed residencies. As other residencies are given final approval we will forward detailed programs. Some of the officers in our present refresher training program will be assigned to those permanent residencies. Your educational committees should function in the permanent program just as they do at the present time. We want these individuals evaluated every three months as at present. The number of individuals assigned to a residency will depend on the number of admissions to that particular service. On an average it takes two hundred to four hundred admissions in the specialty to support one officer in that residency.

Officers who came into the Regular Army in 1939-1941 have had very little professional background will be assigned to mixed residencies in preparation for further training in a specialty. Each will be given a chance to choose his specialty insofar as is consistent with requirements. The Medical Department will have a chance to evaluate the officer before his assignment to a residency. Those officers who have had seven to fourteen or fifteen years of service - in other words, those who had quite a little professional background before the war - will be assigned to the other residencies. I think it will take us about four to six months to completely progress from our present refresher course into this training program. The residency programs are being written and will be distributed at the time the formal residencies are announced.

This, gentlemen, is purely a competitive program. Keep that in mind. If we have an officer assigned, either to our refresher training or permanent specialty training program, who shows by a lack of skill or enthusiasm or willingness to put forth the required amount of work and effort necessary to go on to board certification, he should be pulled out and put somewhere else. We are dependent to a great extent upon your educational committee to give us that information. The Regular Army is short of doctors right now, and we are going to be short for some time. You cannot interest a young doctor in the Army from the financial standpoint, for it's a cinch he can make more money in civilian practice. If we can show him that his opportunities for professional advancement and training, on up to board certification, are as good or better in the Army as in civilian practice I think we will interest some of them. Some individuals believe that if we train our Regular officers on up to board certification that they will resign. I believe that if we can set up an educational system such as has been proposed, we will have plenty of doctors who are eager to come into the Army. We must pick our officers at a younger age and so plan their careers so that their training and assignment lead to board certification. The only way we can do that is to make our general

hospitals teaching institutions, and we should do all in our power to accomplish this. This responsibility will be largely yours as commanding officers of the general hospitals.

Now, just a brief description of the postwar Medical Department school system, to show you where this residency program fits in. I realize that I am just a bit premature in presenting this, because it does not have War Department approval, nor has it been submitted to The Surgeon General for his approval. It is just now being coordinated with the Army Ground Forces, the Army Air Forces, and the Army Medical Center here at Washington. The War Department has recently approved the Gerow School System for the Army. The Gerow Board plan and the schools contemplated do not quite fit the Medical Department and we are going to ask, in submitting this to the War Department, to have certain exceptions made to the Gerow Board system. The Resources and Analysis Division of the Office of The Surgeon General has made an analysis of the requirements for specialists. This school system is planned and is so coordinated to meet these requirements.

(Showing chart, the Medical Department School System, inclosure No. 15.) The arrows merely indicate a general flow of officers. There will be exceptions to it. Every officer will not follow a particular arrow, but there is shown the general flow of the bulk of officers. There will be certain training which is now shown on this chart. Medical supply will need a certain number of men highly trained in depot operation, in storage and distribution, but that number is so small it does not pay to set up a school. These are the formal schools. Now, the Gerow Board requires three schools. It requires what is called a basic officers' course, basic military training, and I will explain that in just a moment. It requires, also, a basic branch course, and an advanced branch course. These are required by the Gerow Board of all officers coming into the Army regardless of arm or service. All officers will go to a common school. They will all be grouped together in one Basic Branch Immaterial School where they will be taught all the things an officer should know about the Army in general. Our doctors will be in that group. West Point graduates are assigned to the same group. When we found that out, it became quite evident that you cannot take a doctor and put him in with a group of West Point graduates. So, we have asked G-3 to take all the doctors — the chaplains, also, are included -- that come in from civilian life, one month early, and send them to the Basic Branch Immaterial School at Fort Riley for a one-month's course in very basic military subjects. The medical officer will take a one-month's course and will then be ready for the four-months' course with the other officers.

The Gerow Board provides that graduates of this first four-months' course will be turned over to their respective branch: Infantry, Quartermaster, Artillery, etc., for a five-months' basic branch course.

For Medical Department officers this course will be conducted at the Medical Field Service School at the Brooke Army Medical Center, Fort Sam Houston. The very basic subjects will be eliminated from the course and more of the Medical Department subjects will be given. At the present time a four-months' basic branch course is contemplated for Medical Department officers.

After the officers first year in the Army we can see that this is a good time tp pick out Medical Service Corps officers who are going to be adjutants, personnel officers, supply officers, and other officers to work in hospitals. We should give them a three-months' course in hospital administration before assigning them to duty. It is also a good time to pick men trained in medical equipment maintenance and send them to St. Louis for a course in medical equipment maintenance before assigning them to duty.

A certain number of medical officers will go to the Air Corps where they will take a basic aviation medicine course of one-month's duration before being assigned to duty. Between two duty periods they will be sent to aviation medicine course to become flight surgeons.

The Gerow school system requires, next, that sometime between the third and tenth years of an officer's career he will be given an advanced branch course. This course is designed to specialize individuals in their particular branch.

Certain common subjects are required to be taught to all officers attending the advanced branch course. A four-months' course is considered to be ample for the Medical Department. Based on the present planning policy for the size of the Medical Department, the size of classes would be 170 to 190 officers. At this point or sooner, officer's careers should be planned. There is a career planning policy being set up by the War Department and the Office of The Surgeon General. We should plan an officer's career very early and have his assignments and training working toward that goal. Individuals going on in professional work for board certification should be sent to general hospitals for residency training. From the advanced branch course some may go to civilian institutions, public health, or civilian hospitals for specialty courses. Some may go to the school for military neuropsychiatry, a four-months' course. School of basic sciences is now taken care of in civilian medical schools. We expect to have our own course in basic sciences soon. Laboratory medicine, a nine-months' course, will fit in closely with basic sciences. In time we plan to set up our own course in preventive medicine, a course equal to or better than the ones given in civilian institutions.

Also, we visualize a course in tropical and global medicine. This will be mostly research, and a portion of the course will possibly be given in Panama, at the Army School of Malariology, or in Puerto Rico.

Another branch of the advanced course will be a course in hospital administration for commanding officers. Possibly, we could send a few Pharmacy Corps officers whom we would desire to train for executive officer duties. Then, to complete the advanced course, we will have advanced dental and the advanced veterinary courses. It is planned to locate the courses as follows:

Brooke Army Medical Center
- Basic Branch Course
- Advanced Course
- Hospital Administration Courses (both basic and advanced)
- Optical Repair Course
- Military Neuropsychiatry

Army Medical Center
- Preventive Medicine
- Laboratory Medicine
- Basic Sciences
- Tropical and Global Medicine
- Advanced Veterinary Course

St. Louis Medical Depots
- Army and Navy Equipment Maintenance Course

Quartermaster Depot, Chicago
- Meat and Dairy Hygiene Course

Randolph Field
- Basic Aviation Medicine
- Advanced Aviation Medicine

This, then, in general, is the plan for the Medical Department school system. It is not yet firm and is now being coordinated with the various agencies.

Colonel Caldwell, Chief, Neuropsychiatric Consultants Division, OSG made the following statements in regard to training in neuropsychiatry:

As you know there are some unusual features about training in neuropsychiatry. I would like to state some of the problems that we are up against. In maintaining a 500,000 army, we need about 130

psychiatrists. In a 800,000 army we need about 200 psychiatrists. We now have approximately twelve in the Regular Army not including those with the Army Air Forces. Thirteen medical officers are assigned to hospitals for residency training in neuropsychiatry. The Army is concerned about what we are going to do next spring. We will need replacements for "B&C" men now in the service. Where are we going to get these 130 psychiatrists? We will have to use officers for professional training in the Army from the present ASTP groups. We will not get many from the outside. There isn't much inducement to come in on the next integration. The Veterans Administration is bidding against us with at least twenty-five percent increase in pay. We will have to train men from our own rank; train from eight to ten in each hospital. Requests are coming in for replacement for clinical psychiatrists. We do not have replacements for clinical psychiatrists, many are going out of service. Hospitals are hiring clinical psychiatrists. If your hospital has hired a clinical psycologist, write up his job sheet and send it to the Civilian Personnel Division for a rating. We will continue to train neuropsychiatrists and nurses in neuropsychiatric nursing. We will need a number of neuropsychiatric technicians. Courses will be set up at Brooke for the training of these technicians, also, for the training of clinical psychologists and psychiatric social workers.

DISCUSSION:

Colonel Duke discussed questions on education and training that had been submitted by hospital commanders.

Question 1: How many months will the medical officer trainee be at this hospital for training? This influences the training program vitally. If assurance could be given that when a trainee arrives at this hospital he will be here for a definite period of time, the training program could be adjusted in accordance and would enable the trainee to receive maximum benefit during his training period. (Submitted by: CO, Pratt General Hospital.)

Answer : Officers assigned to a general hospital for refresher training will remain at this hospital for at least six months. This is the minimum time. Whenever possible the time will be extended. However when the officer's services are needed by the Personnel Division of The Surgeon General's Office for a duty assignment, it will be necessary to withdraw him from a training status and to assign him to duty. If this assignment is in a general or large station hospital the officer will be still considered to be in training and quarterly reports will be rendered on him by the educational committee. These reports will continue until he has been certified by an American Specialty Board.

Question 2: Is there a planned training program drawn up in the Training Division outlining the scope of training desired? Such master program to be used as a guide in the various hospitals. (Submitted by: CO, Pratt General Hospital.)

Answer : For the refresher type training the training program is outlined in paragraph 6, AR 350-1010. In the permanent residency training detailed training programs are being drawn up for each specialty. In the near future as residencies are approved by the AMA and American Specialty Board in the various hospitals these programs will be forwarded to the hospitals.

Question 3: The problem has arisen at some hospitals of not having sufficient well-qualified medical officers on the staff to conduct both a competent program of professional service to the hospital and of training new officers in interim refresher courses, interne and residency training programs as well as the continuing program of training enlisted men and enlisted women technicians. Will there be available in the near future sufficient qualified medical officers to meet the needs mentioned? (Submitted by: CO, Pratt General Hospital.)

Answer : The Army has recently integrated into the regular service about twenty-six board members. About thirty Regular Army officers will become board members within the next six months. It is hoped that our present educational program will in the near future make available more well qualified medical officers for the staffs of our hospitals.

Question 4: Is it the policy of your office to order regular officers undergoing refresher training, to civilian institutions for training in the basic sciences required for board certification? (Submitted by: CG, Fitzsimons General Hospital. Coordination: Office of Personnel.)

Answer : It is the policy of The Surgeon General's Office to order Regular Army officers undergoing refresher training to civilian institutions for training in the basic sciences required for board certification. Four such courses are now in progress and the fifth one is being established next month. These courses are being conducted at George Washington University, University of Colorado, University of Michigan, University of California and Washington University in Seattle. It is anticipated that additional such courses will be established from time to time. Officers who are nearing their examinations for the American Board are given preference to these schools.

Question 5: Rotation of officers assigned for professional training on various services. For example, an officer is assigned for professional training in chest surgery at Fitzsimons General Hospital. In order to properly prepare for his board in this field, it is necessary that he have training on general surgery. Do we have authority, in view of the way the orders are written, to rotate such an officer for training in other sections of surgery, without requesting a change in orders? (Submitted by: CG, Fitzsimons General Hospital.)

Answer : The answer to this question is, "Yes!" If training in other fields is required for certification in a particular specialty the hospital is authorized to assign the officer to meet these requirements. However, to completely change the officer's assignment from one specialty to another must be coordinated with and be approved by The Surgeon General's Office.

Question 6: Does the Army plan on training and using their own specialists and expert consultants? (Question submitted by CO, Mayo General Hospital.)

Answer : The Army definitely plans on training and using their own specialists and expert consultants. This is the very reason for our career planning policy and educational program. However, the accomplishment of this will require some time.

Question 7: When will T/O units be adequately staffed to perform unit training tentatively scheduled at this station for 23 August 1946? Officers presently assigned to these units are not qualified by training or experience to direct their units in such training activities. Despite T/O authorizations, there are no field grade officers assigned to any units in training at this installation. (Submitted by: CO, Percy Jones General Hospital.)

Answer : There is at present assigned or ordered into the General Reserve units about 2/3 of their authorized strength of MAC officers. Also a few Medical Corps officers have been and are being assigned. The highly qualified professional officers to be chief of services and sections will not be assigned until movement is imminent. Wherever there is not a qualified commanding officer assigned, this fact should be made known to the Personnel Division, Surgeon General's Office.

Question 8: Who will determine when T/O units are qualified to proceed from MTP 8-1 to MTP 8-2, etc.? Uncertainty exists as to whether this determination may be made by the commanding general and director of training of the installation at which they are receiving their training or if it will be made by an inspection team from The Surgeon General's Office. (Submitted by: CO, Percy Jones General Hospital.)

Answer : The decision as to when T/O units are qualified to proceed from MTP 8-1 to MTP 8-2 is given by the Director of Military Training, WDGS. The latest information received from that office is that MTP 8-2 will not be started until 75% of the technicians in each unit have finished their technical training. We were told that a directive on training of General Reserve units was in the process of being published now.

I. PROFESSIONAL ADMINISTRATIVE PROBLEMS IN ARMY HOSPITALS .....Colonel A. N. Nylen

Colonel A. N. Nylen, MC, Chief of the Physical Standards Division, OSG, introduced Major John H. Holliday, AGO, who discussed briefly essential changes in a proposed revision of WD Circular 313, 1945, placed in immediate effect by AG letter, 22 August 1946, Subject: "Disposition of officers subsequent to appearance before Army retiring Board":

1. Officers who are under orders for separation, or are eligible therefor, and officers ineligible for separation but who have been found physically incapacitated for all types of military duty may elect to be retained on active duty in a patient status, pending final War Department action on their case. When the Army retiring board proceedings have been completed, the hospital commander will obtain a statement signed by the officer expressing his desires reference remaining in patient status, or relief from active duty, and take appropriate action as follows:

a. If the officer desires immediate separation, he will be separated at the hospital under current procedures and copies of the relief order and the officer's statement declining retention in a patient status will be forwarded to the War Department together with the Army retiring board proceedings. Officers found not incapacitated and who are eligible for separation will not be transferred to separation centers but will be processed at the hospital. Records and pay accounts will be retained at the hospital until officers revert to inactive status.

b. If the officer elects to be retained in patient status pending final War Department determination, the hospital commander will include the officer's statement with the Army retiring board proceedings indicating that he is eligible for relief from active duty but desires retention in patient status pending War Department instructions. Hospital commanders are authorized to grant sick leave in the amount they deem necessary.

(1) If, as a result of War Department action, the officer is considered qualified for temporary limited service, The Adjutant General will so notify the hospital commander, who will ascertain the officer's desires regarding reassignment. An officer who elects to be separated will be processed in accordance with paragraph 1a above. An officer who elects to continue on

active duty for the period of temporary limited service recommended will be reported to the War Department, Attention: Central Officers Assignment Group. Reports will include the following information: Name, Grade, and ASN, arm or branch of service; efficiency index; military occupational specialty; color; limitations as to type of service and locality, if any; date officer will report for re-examination; copy of 66-4, if available.

(2) Officers who are found by the War Department to be qualified for general service and who desire continued active duty will be processed for separation and be informed that they should communicate with The Adjutant General's Office, regarding recall to active duty.

2. If, at the time of processing for relief from active duty, an officer is found to be in a temporary limited service status with instructions to return to a medical facility for re-evaluation at the expiration of the period of temporary limited service, he will be cautioned that if he still desires re-evaluation after his separation from the service he should apply to the Adjutant General for written authority to enter an Army hospital at the appropriate time, unless he has received such authority.

Lt. Colonel D. D. Holland, MC, of the Physical Standards Division, OSG, discussed policies of the Office of The Surgeon General in handling the proceedings of Army retiring boards. Copies of "Notes on Conference on Procedures Governing Retirement of Officers for Physical Incapacity" held at the Pentagon earlier in the year were distributed. These notes cover in detail policies in effect and usual causes for delay in processing.

DISCUSSION:

Colonel Nylen discussed questions pertaining to professional administrative problems that had been submitted by hospital commanders.

QUESTION 1: Can a clear-cut policy be laid down for the disposition of all patients (detachment of patients unassigned status) of all services who are returned to a duty status? (Submitted by CO, McCornack General Hospital)

ANSWER: It is believed the proposed revision of WD Circular 313, 1945, "Physical Reclassification of Officers", which should be out shortly, will adequately provide for the disposition of types of patients mentioned.

QUESTION 2: How may line of duty be determined in the case of injuries received overseas when no board proceedings are available?

DISCUSSION:

In the case of many injuries received overseas, involving both officers and enlisted men, insufficient evidence is available to determine line of duty. This results in a considerable delay in completing the disposition of the patient. It is recommended that hospital boards of officers be permitted to determine line of duty from clinical and other records available and by personal interviews. This would prevent long delays in disposing of patients with doubtful line of duty status. (Submitted by: CO, Percy Jones General Hospital).

ANSWER: AR 345-415 outlines the procedure in LOD cases. Where proceedings of boards of officers which should have been convened at the time of the injury are not available or obtainable, it is believed proper to convene a board to act on all information obtainable from records or interview and arrive at a decision. The proceedings should show the result of effort made to obtain information from the individual's oversea station (concurred in by Legal Division, SGO). Army retiring boards may determine the LOD in any case before it independently of any determination which may have been made previously.

QUESTION 3: Is it necessary for an officer to appear before a disposition board prior to appearing before an Army retiring board when he has a letter from The Adjutant General's Office authorizing him to appear before an Army retiring Board? Many officers, who have been marked six months temporary limited service and who have been separated from the service, are reporting to this hospital at the end of the six months period with a letter from The Adjutant General's Office authorizing them to appear before an Army retiring board. In such cases it appears that appearance before a disposition board as a prerequisite to appearance before an Army retiring board is superfluous and time wasted when the letter itself authorized the officer to appear before an Army retiring board. (Submitted by: CO, Pratt General Hospital)

ANSWER: Any officer who is scheduled to appear before an Army retiring board should appear before a disposition board within 30 days prior to his appearance before such board. This is considered to be warranted inasmuch as the findings of the disposition board constitute valuable evidence for consideration by the retiring board.

QUESTION 4: Should such a transfer be made by a hospital--without first coordinating with The Surgeon General? Even though that officer may be on a civilian status?

DISCUSSION:

In the case of AUS officers who were put on six months temporary limited service. John Doe, 1st Lt., AUS, met an Army retiring board at Camp Blanding, Florida. The board found Lt. Doe incapacitated and he was placed on terminal leave. The Surgeon General did not concur with the findings of the Army retiring board, and recommended a six months period of temporary limited service with re-examination and re-evaluation at the expiration of that period at a neurological center. In the meantime, the hospital at Camp Blanding closed. Subject officer is on a civilian status. The proceedings of the Army retiring board go back to The Adjutant General's Office for necessary action. Lt. Doe is recalled to active duty and ordered to a named general hospital nearest his home. It so happens that Lt. Doe is spending his terminal leave in another section of the country, so requests permission from the hospital where he was ordered to enter a general hospital near where he is spending his leave. Thus, his papers are transferred to the new station.

ANSWER: WD Circular 313, 1945, provides that an officer who has been found not permanently incapacitated for active service and who has been placed on six months temporary limited service status and who has, prior to the expiration of this prescribed period, reverted to an inactive status, may, upon submission of his written request to The Adjutant General's Office, receive authorization to enter the Army medical installation nearest his home for appearance before another Army retiring board. If such an officer desires to enter the hospital nearest the place where he is spending his leave rather than the one nearest his home, he should submit a request to this effect to The Adjutant General. If such an officer has been admitted physically to the Army general hospital nearest his home, it appears unwarranted to effect his transfer to the hospital nearest the place where he was spending his leave. If, however, this officer's papers were merely transferred to the hospital nearest his home and he had not physically appeared at that hospital, then if he wishes to be admitted to the hospital nearest his place of leave, he should submit a request to such effect to The Adjutant General's Office in writing. The commanding officer of the hospital receiving an officer in the status of a civilian at the expiration of his TLS period should, if he believed that the case should be transferred to another hospital for correct management, submit a recommendation to this effect to The Adjutant

General's Office. If, however, the officer in question has been recalled to active duty upon the expiration of his TLS period, the hospital commander could effect his transfer to another hospital under the directives and policies now governing the transfer of patients from one hospital to another. It is believed that such transfers of patients from one hospital to another should be governed by the medical indications in the case.

QUESTION 5: The officer was ordered to a hospital by The Adjutant General's Office for a purpose--probably because the general hospital was a neurological center. The new station does not have a neurosurgeon to accurately evaluate the case. If the Army retiring board finds that man not incapacitated, then the officer can criticize the Army and probably bring political pressure to bear. (Submitted by: CO, Pratt General Hospital)

ANSWER: In cases where the services of a specialist, not available on the staff, are believed essential for the proper evaluation of a given case, consideration should be given to obtaining a consultation with a qualified civilian specialist or effecting transfer of patient to a hospital where such specialized service is available. It is not believed the thought of criticism alone should be the determining factor, but rather whether available personnel can properly evaluate the case.

QUESTION 6: If the officer appears before an Army retiring board and introduces his own medical witness, who is a neurosurgeon, and the witness testifies to the effect that Diagnosis #1 was aggravated by military service and Diagnosis #4 was of a severe nature, and the recorder of the Army retiring board does not have available a neurosurgeon to represent the Government as a medical witness or a consultant, what disposition should be made of the case? Should the recorder recommend to the board--in behalf of the government--that subject officer be transferred to a neurological center? Should the board recommend the transfer? Or should the board weigh the evidence given by the officer's medical witness and leave it up to the reviewing authority to make the decision? (Submitted by: CO, Pratt General Hospital)

DISCUSSION:

An officer appeared before an Army retiring board. The board found the officer incapacitated by reason of:

1. Post-traumatic cerebral syndrome, moderate, manifested by grand mal attacks, incurred following auto accident at age 16.

2. Fracture, compound, complete, comminuted, left tibia at junction of middle and upper third, incurred 8 April 1944, at New Guinea, in jeep accident.

3. Fracture, compound, complete, comminuted, end of left fibula, incurred as in 2 above.

4. Neuritis, traumatic, chronic, left common peroneal nerve, secondary to 2 above.

The Surgeon General did not concur with the findings of the Army retiring board, in that the four diagnoses as stated are incidents of the service--

Diagnosis #1 was LOD: No - EPTS.
" #2 was healed.
" #3 was healed.
" #4 - The board did not state the severity.

The Army retiring board reconvened for a rehearing and found the officer not incapacitated and recommended a period of six months temporary limited service. The officer was authorized to enter a general hospital for observation and appearance before an Army retiring board. The disposition board recommended an appearance before an Army retiring board.

ANSWER: A retiring board should always weigh the evidence given by every witness, whether he be one of the appointed medical witnesses or a witness called on behalf of the officer before the board. It is difficult to conceive how a post-traumatic cerebral syndrome, manifested by grand mal attacks, incurred at the age of sixteen, could possibly be aggravated by military service several years later, notwithstanding the testimony and opinion of any neurosurgeon. However, the neurosurgeon's opinions as to the severity of the traumatic neuritis should be given considerable credance. But the medical members of the retiring board should require the neurosurgeon to demonstrate in exactly what way this neuritis is severe and in what way it incapacitates the officer for military service. Having proceeded as just indicated, the board should then determine whether further observation in a neurological center is indicated for the proper disposition of the case, or whether it is prepared to render unequivocal findings as to whether or not subject officer is permanently incapacitated for active military service. The findings and

recommendations of the board would be weighed, in the light of all evidence, by the reviewers in The Surgeon General's Office, and such recommendations would then be submitted as evidence at hand should warrant.

QUESTION 7: Can a member of the detachment of patients at a general hospital be marked quarters for their convenience and reside with their families in town at the discretion of the commanding officer? May charges be made for rations? The advantage of this would be the release of beds in the hospital. (Submitted by CO, Pratt General Hospital).

ANSWER: The change of status from hospital to quarters or quarters to hospital would appear to be within the discretion of the hospital commander. Charge should not be made for subsistence while in a quarters status. Care should be exercised in having individuals who may not be drawing an allowance for quarters understand this is a privilege and that claim for quarters allowance will not be considered.

QUESTION 8: Why must officers appearing before disposition boards, whose appearance before a retiring board is not contemplated and who are not eligible for separation, or on terminal leave, be required to await action from the War Department before they can be returned to duty?

DISCUSSION:

In the past, officers in this category were sent to reception centers for processing and reassignment as soon as the disposition board had completed action. Under the new system, a considerable delay takes place before officers can be dispositioned. The same problem exists for enlisted men, inasmuch as delay often results after army headquarters had been contacted since in many cases they seen uncertain as to where the enlisted men should be sent for duty. (Submitted by: CO, Percy Jones General Hospital)

ANSWER (TAG): Officers found not incapacitated by disposition boards should, in accordance with WD Circular 87 as amended by WD Circular 244 be reported to TAG for assignment instructions if their previous commanding officers have not requested their return. Officers recommended for temporary limited service should also be reported to TAG under such circumstances. A War Department Circular is presently being prepared which will include specific instructions as to disposition of such officers.

QUESTION 9: A recent directive states that an officer within the continental United States transferred to an army general hospital will not be returned to the station from which admitted unless a written request is received to that effect from his commanding officer; otherwise, and in the case of an officer admitted from overseas, report must be made to The Adjutant General fifteen days prior to the time he is ready for duty. From former experience in requesting orders from The Adjutant General, it is our opinion that this directive would result in the retention of many officers in hospitals for a considerable benefit. Also, it is not always easy to say fifteen days in advance when an officer will be ready for duty. (Submitted by: CO Army & Navy General Hospital).

ANSWER(TAG): Under provisions of WD Circular 244, 1946, officers who are qualified for return to general duty upon completion of hospitalization will not be returned to station from which admitted except upon written request from the CO of that station. All other cases, except cases involving officers of the AAF, will be reported to TAG for disposition instructions. Under present policy such cases are being processed in accordance with a newly established procedure, and it is anticipated that assignment instructions will be forthcoming more rapidly than in the past.

QUESTION 10: Officers who have been separated from the service following appearance before a retiring board, who are later recalled, with their own consent, for reappearance before a retiring board, should be informed of the length of time that such reconsideration will involve. Many come in thinking that they will be away from home for a few days and find that they are retained for three or four weeks, due to the necessity for obtaining their records from The Adjutant General's Office, and because of the pressure of work upon new medical officers with little experience in such matters. Recommend that when an officer is ordered to active duty for the purpose of meeting an army retiring board, The Adjutant General automatically forward to the general hospital all necessary papers. (Submitted by: CO, Army & Navy General Hospital).

ANSWER(TAG): Present policy of The Adjutant General is and has been since 1 June 1946 to either authorize or order an officer to enter a hospital from an inactive status and immediately thereafter dispatch the medical records to the designated hospital. It is believed that at the present time and in future cases no delay should be experienced in disposing of an officer's case by reason of failure to receive necessary records from The

Adjutant General's Office. It is impossible for The Adjutant General to estimate the duration of an officer's stay in a hospital. However, whenever an inquiry is received as to the probable duration of such hospitalization he is requested to contact the commanding officer of the hospital.

QUESTION 11: Recommend that a general hospital be authorized to separate officers who have been ordered back to active duty for the purpose of rehearing before an Army retiring board. At the present time they must be sent to a separation center and repeat a process they have once before gone through. (Submitted by: CO Army & Navy General Hospital).

ANSWER(TAG): a. Officers separated for reasons other than physical disability, admitted to an Army hospital either from terminal leave or who have been recalled to active duty for Army retiring board action, who are found incapacitated for active service by an Army retiring board, should be relieved from active duty by reason of physical disability by the hospital under authority of Circular 313 and need not be transferred to a separation center for reprocessing In cases of such officers who are admitted from terminal leave, who, after physical reclassification are found to be permanently incapacitated for active service the separation centers to which the officer had been previously assigned should be requested to transfer the officer to unassigned detachment of patients of the hospital involved and issue orders relieving him from active duty for physical disability.

b. (1) Officers being separated for other than physical disability, who are admitted to a hospital from terminal leave and who are found to be qualified for general service need not be sent to a separation center, but will be restored to a terminal leave status and the separation center notified of the duration of the hospitalization in order that the officer's leave can be recomputed and his relief orders amended. (See WD Circ 116, 1946).

(2) Officers recalled from inactive status to active duty for the purpose of appearing before Army retiring board, who are found not incapacitated need not be sent to a separation center for processing but may be separated at the hospital. (Instructions providing for separation by the hospital of all personnel who are eligible therefor will be forthcoming in the near future).

QUESTION 12: In the case of officers ordered into hospital by TAG from terminal leave for reconsideration there is a variation of policy emanating from Fourth Army Headquarters, from that published in various War Department Circulars. Illustration: 1st. Lt. Catton, ANC, was ordered to Cushing General Hospital by TAG from terminal leave and subsequently transferred by Cushing General Hospital to this hospital; upon completion of treatment here, returned to terminal leave in conformance to WD Circular 116; returned to her home in Mass. at her own expense; after her departure we were advised by TAG to separate her at this hospital. There are numerous other instances. (Submitted by: CO, Army & Navy General Hospital.)

ANSWER(TAG): The provisions of WD Circular 116, 1945 are not applicable to officers who are ordered to proceed to an Army hospital upon specific instructions from the War Department. Further, it does not apply to officers who are admitted to an Army hospital from terminal leave who are under orders for separation for other than physical disability but, who, after necessary hospitalization are determined to be physically disqualified for general military service. Such officers should be transferred to detachment of patients and disposed of in accordance with the provisions of WD Circular 313, 1945. (If the officer had previously collected travel from the separation center to his home he should be required to reimburse the travel pay collected under the original separation center).

QUESTION 13: The retiring board proceedings in cases of officers suffering with tuberculosis have been returned for reconsideration in some cases with comments from The Surgeon General's Office that are not well understood by those officers conversant with these cases at Fitzsimons General Hospital. Some of these cases are diagnosed as active tuberculosis and some as apparently arrested. As is well known, the term "apparently arrested", at best, hazily describes the actual condition of the tuberculous lesion. As a matter of fact, it is not intended to convey any final prognostic information. The term is ordinarily applied in cases that have been active within recent months. We know of no one recognized in the field of tuberculosis who would recommend any type of duty on such cases for an indefinite period of time. We have felt at Fitzsimons that a period of two to five years is necessary to establish the permanent stability of such lesions which have been recently active. Colonel Long, recently, in a conversation with the Chief of Medical Service at Fitzsimons General Hospital, felt that five years should be the minimum period of a protected existence in such cases.

ANSWER: The policy of The Surgeon General's Office in reference to the question stated above is outlined in the following paragraphs:

(1) Cases of (a) pulmonary tuberculosis, with or without pleural effusion, (b) pleurisy with effusion without pulmonary tuberculous infiltration, and (c) tuberculous lymphadenitis, will be hospitalized in accordance with the provisions of Section V, WD Circular 122, 1946. Patients with continuing active disease and patients with inactive disease moderately or far advanced in extent, will be retired. Patients with minimal tuberculosis who achieve apparent arrest of their disease, as determined by accepted criteria (see Diagnostic Standards of the National Tuberculosis Association), if not eligible for separation, will be returned to limited duty, with provision for chest x-ray observation in pulmonary and pleural cases each three months and careful medical re-evaluation each six months. Ultimately (within two years of the period of apparent arrest) such cases may be adjudged either active or apparently cured. If they have reached the latter state and are eligible for separation from the service they should be separated without retirement.

(2) If, however, patients in the categories here considered have reached the state of arrest or apparent arrest only, and are eligible for separation from the service and elect to be separated, they will be separated under Section V, WD Circular 122, 1946, which provides that officers with favorable prognosis may be hospitalized up to one year and that officers with inactive tuberculosis will not be retired. In such cases the retiring board should recommend that the officer be found not permanently incapacitated for active service, and that he be placed on temporary limited service status for six months, with re-examination and re-evaluation at the end of that time. Within the discretion of the board, a second six months period may be recommended in order to allow sufficient time for the apparently cured state to be reached. At the end of the first or second of these six months period it should be possible to determine if the disease in question is apparently cured or still active, and render a final opinion with reference to incapacitation and retirement.

J. PREVENTIVE MEDICINE PROBLEMS IN ARMY HOSPITALS.....Colonel Tom F. Whayne

Colonel Tom F. Whayne, MC, Deputy Chief of Preventive Medicine Division, Office of The Surgeon General, was introduced by General Kirk. Colonel Whayne made the following statements:

There is not a great deal in preventive medicine to come before the meeting, but I thought it necessary to bring up two or three matters.

The first thing to be referred to is WD Circular 138, 1946. There seems to have been some variation in the interpretation of paragraph 6W, which designates the responsibility of the commanders of Class II installations within the army commands. As we interpret it, commanders of Class II installations are required to report problems with regard to preventive medicine, sanitation and hygiene, venereal disease control, nutrition and liaison with civilian public health agencies to the army commanders. The army commander is responsible for his entire area with respect to these problems. It is obvious that they must cooperate with civil agencies and coordinate problems in a capacity that goes far beyond the confines at Class II installations themselves.

One other minor matter is the routing of Class II sanitary reports. A change is being made in Army Regulations 40-275; necessary concurrences have been submitted and permission to publish this regulation has been granted. This change directs that sanitary reports from Class II installations will be submitted to army commanders. This is necessary so that the army commander can make a comprehensive sanitary report for the area of army jurisdiction.

Concerning the diphtheria immunization program that was set up in WD Circular 211, 1926, Lieutenant Colonel Long will comment on that and give our reasons for its adoption. Also, Colonel Long will comment very briefly on influenza control. We would like to ask your cooperation in certain phases of the influenza program for the coming year.

Lieutenant Colonel Arthur P. Long, MC, Chief of the Infectious Disease Control Branch made the following statements in regard to influenza and diphtheria control:

We don't know if we are going to have influenza again this year or not. From the experience of the last twenty-two years, there may well be at least a moderate outbreak. There was no "sentinel outbreak" last spring. The decision has not as yet been made whether or not we will apply routine influenza vaccination in the Army again this year. What I would like to ask is that you commanding officers of army hospitals will have

your chiefs of medical service when they have cases--truly suspicious influenza cases--submit acute and convalescent serum specimens on those cases for specific diagnosis. We have only two laboratories manned to do this diagnosis at this time. One is the Army Medical School the other is the Sixth Army Laboratory at Monterey. Within the next few weeks or a month we hope to have at least one or two other laboratories equipped to do influenza diagnoses. You will be informed through proper channels of the availability of these laboratories. If you find anything that looks like influenza let us know and send in a few serum specimens. We don't want a lot of specimens--actually, a dozen or two dozen paired specimens from suspicious cases is all that is required.

As for diphtheria, most of you recall that about a year ago an ASF Circular set forth instructions for the immunization of all personnel in general hospitals who might come in contact with this disease. At that time about sixty-five percent of the diphtheria in this country was occurring in general hospitals. In July of this year all ASF Circulars were rescinded and WD Circular 211 came out with instructions that all hospital personnel likely to come in contact with diphtheria must be immunized. We feel that this is still a good program. Diphtheria is becoming quite a problem in the young adult group. Knowing that this is a difficult procedure, it certainly can be done better in a hospital where there are people who can do this work. Because of reactions, it is a difficult thing to do in adults. For that reason, I think it can best be done in a good medical installation.

Another thing, I would suggest that you don't line up the whole staff of diphtheria immunization at one time. Don't do large segments all at one time because you may get into trouble. Use the outline in TB Med 114. It is not perfect but you will have less trouble.

Colonel Whayne stated that there are two questions on laboratories: relationship of army area laboratories and one question with regard to the chief of laboratory service in hospitals. He asked Lieutenant Colonel Cavenaugh to discuss these points.

Lieutenant Colonel Robert L. Cavenaugh, MC, Chief of the Laboratories Branch made the following statements:

There are two points in regard to laboratories. One, the relationship of laboratories in general hospitals to the army area laboratories. The status of the army area laboratories is a little bit uncertain at the moment. A request has gone in for all six army laboratories to be transferred back to The Surgeon General as Class II installations, just as are all the general hospitals. But regardless of whether they are Class II installations or are under the army commanders, we still want to have them considered as "general" in function, because they provide a general service to all the installations in the area, which includes

general hospitals. They provide laboratory service of the preventive medicine type to general hospitals. Also, it is recognized that the chiefs of these laboratories, who are selected men, have a staff of trained personnel to be utilized as laboratory consultants to help you in any laboratory problem which come up. Unfortunately, it is not possible to have an army area laboratory consultant in each area, so the chief of the army laboratory in each area is your best consultant. In case you have a call for a more extensive type of laboratory consultation, there will be a few specialists of the highest type working out of the Office of The Surgeon General, or on call by The Surgeon General. These specialists will be available to serve you.

Another means in which these army area laboratories can be of service to the general hospitals will be in evaluation studies: determinations of unknown specimens in chemistry, serology, bacteriology, etc., sent out to all the hospitals in the area by the army laboratories. The purpose of this is to maintain the hospital laboratory work at the highest level of accuracy, and to obtain help in technical matters where needed. We ask that your hospital laboratory cooperate actively with the requests of the area laboratories. They are of great value to you in maintaining your laboratory procedures at a high level of accuracy.

DISCUSSION:

COLONEL KEELER: Is it planned to continue the laboratory at Fort Lewis?

LT. COLONEL CAVENAUGH: Yes! Approximately as it is now. In other words, it functions as an army area laboratory, but is under your control. Lt. Colonel Cavenaugh stated the other point he wanted to bring up was the question in Sanitary Corps officers serving as chiefs of laboratories. This has happended in a few instances. It is not a desirable situation. If you want a reference to it, paragraph 177, TM 8-260, directs that the senior medical officer assigned to the laboratory service be designated chief of laboratory. Decisions and responsibilities as chief of laboratory should be made by a medical officer, and this will relieve the Sanitary Corps officer of making such decisions. It is a matter of checking to see that this directive is applied in your hospitals.

K. GENERAL DISCUSSION AND SUMMARY.....Major General Norman T. Kirk
Brigadier General R. W. Bliss
Brigadier General Guy B. Denit
Hospital Commanders

Brigadier General Guy B. Denit, Chief of Plans and Operations, Office of The Surgeon General, complimented the hospital commanders on the smoothness with which the change in control of general hospitals from service commands to control by The Surgeon General was made.

In regard to the allocation of personnel to the armies by the War Department Manpower Board for the performance of certain functions at Class II installations, General Denit pointed out that the concern of the hospital commanders should be in the type of service provided--is it adequate?--and not in the numbers of personnel involved. In the bulk allotment of personnel to the armies, the War Department Manpower Board includes a breakdown of personnel, which shows how the board arrived at the allotment. This breakdown is merely for the information of the army and does not restrict an army commander in the utilization of his personnel.

General Denit stated that he was very much impressed with what Colonel Armstrong said about the proper utilization and assignment of medical personnel. He pointed out that we might do a better job of "selling" the Medical Department to our younger men. The advantage of a Regular Army medical career should be pointed out, and our younger officers should be informed of the measures that are being taken to make their careers attractive. He pointed out that he had a chance to talk to three Regular Army Medical Corps officers who wanted to resign, but who, after he had talked with them, were reassured and decided to stay in the Corps.

General Denit mentioned the recent conference of The Surgeon General with the army surgeons, which was a profitable and splendid meeting. One of the matters discussed at that conference was the coordination of medical technical matters at Class II medical installations by the army surgeon. This matter was presented to the War Department and approval given for The Surgeon General to call upon the army surgeons as his technical representatives in medical matters at Class II installations.

General Denit closed his remarks by stressing the need for continued striving--even in the face of economy talk--to make our hospitals the finest in the country--the best physical plants and the finest equipment.

Brigadier General Raymond W. Bliss, Deputy Surgeon General spoke next. General Bliss stated that he was sure that if all the hospital commanders were getting half as much from the conference as he was, the time was well-spent. General Bliss called upon Colonel Turnbull, Commanding Officer of Tilton General Hospital.

Colonel Turnbull agreed that the conference had been a very profitable one. He stated that he had found out things that he had wondered about for long months. He complimented those in charge for the efficiency and competency of everything that was done. Colonel Turnbull had one criticism to make, and that was in regard to messes. He thought that this subject would have been a very illuminating and interesting one.

Brigadier General Charles C. Hillman, Commanding General, Letterman General Hospital and Colonel Cleon J. Gentzkow, Commanding Officer, Valley Forge General Hospital, spoke next. They expressed their appreciation of the opportunity to assemble as they had in conference, and the hope that conferences of this kind might be called more often.

Major General Norman T. Kirk, The Surgeon General, concluded the conference. He emphasized the esprit of the Medical Corps, and the continued striving to have the best medical service available. He stressed the need for good public relations, and for the utilization of the abundance of material available for the training of Medical Department personnel. He made particular reference to the Technical Medical Bulletins and the many excellent training films developed during the war. The TB Meds, stated General Kirk, "Are better than most text books on medicine, and a reference set of them should be available in each hospital library."

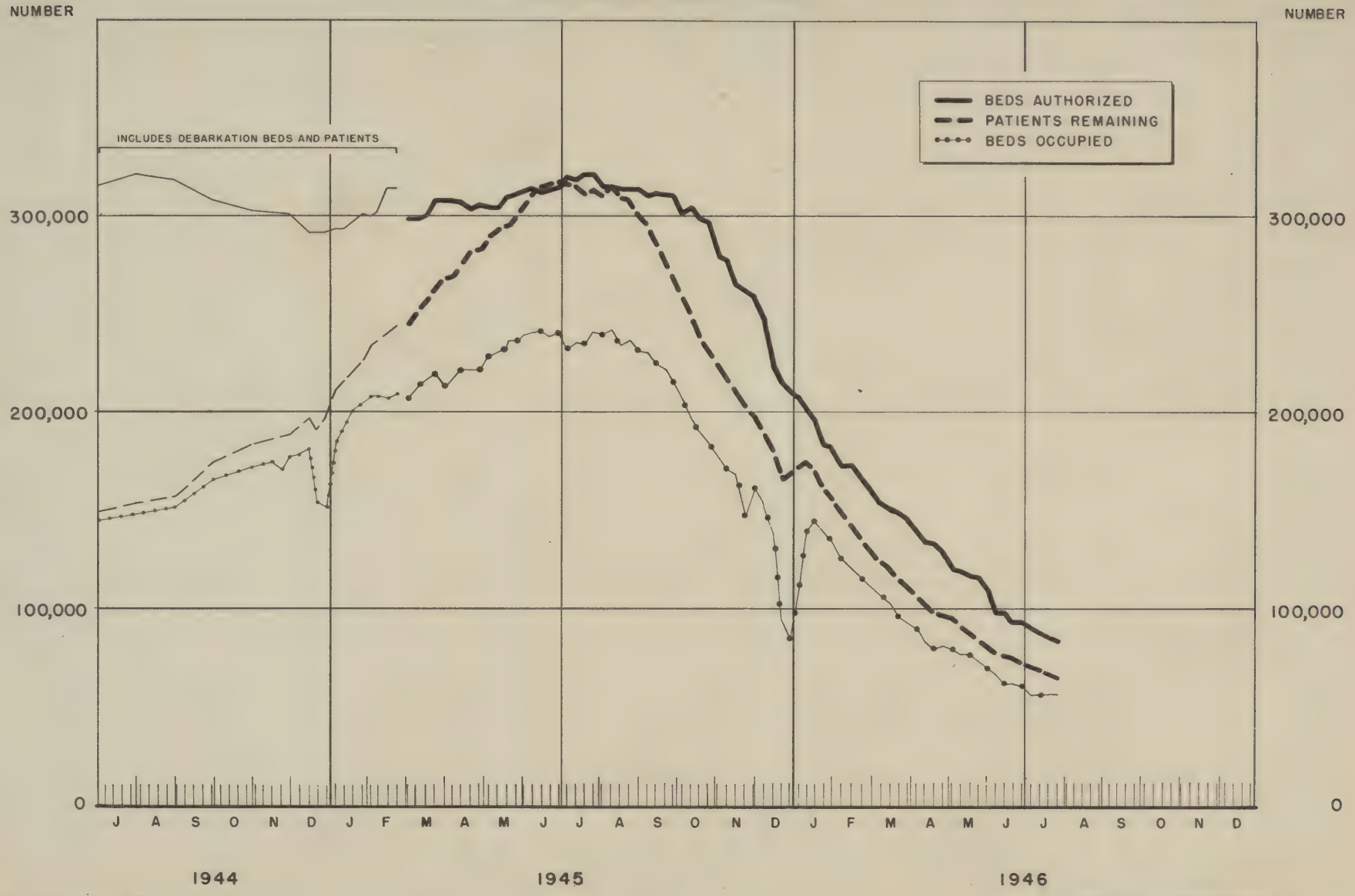
General Kirk mentioned the efforts being made to increase the number of nurses, anesthetists, from three to five in general hospitals, and the ratio of nurses per beds from one to twelve to one to ten.

The conference ended 1600 hours, 23 August 1946.

HOSPITALIZATION DATA

ALL TYPES OF HOSPITALS

CONTINENTAL UNITED STATES



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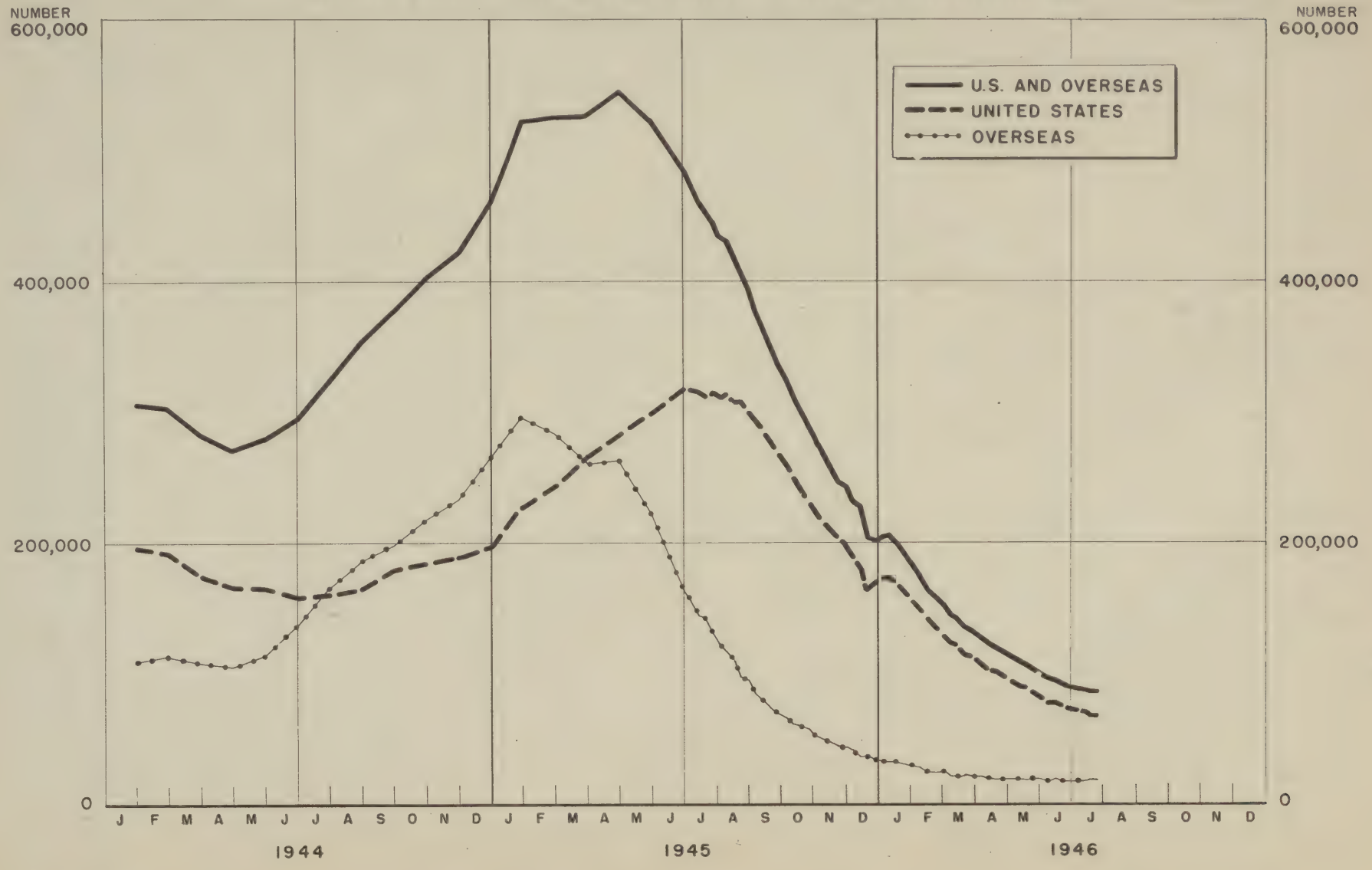
MEDICAL STATISTICS DIVISION, HEALTH REPORTS BRANCH

PATIENTS REMAINING IN ARMY HOSPITALS

(INCLUDES BOTH ARMY AND NONARMY)



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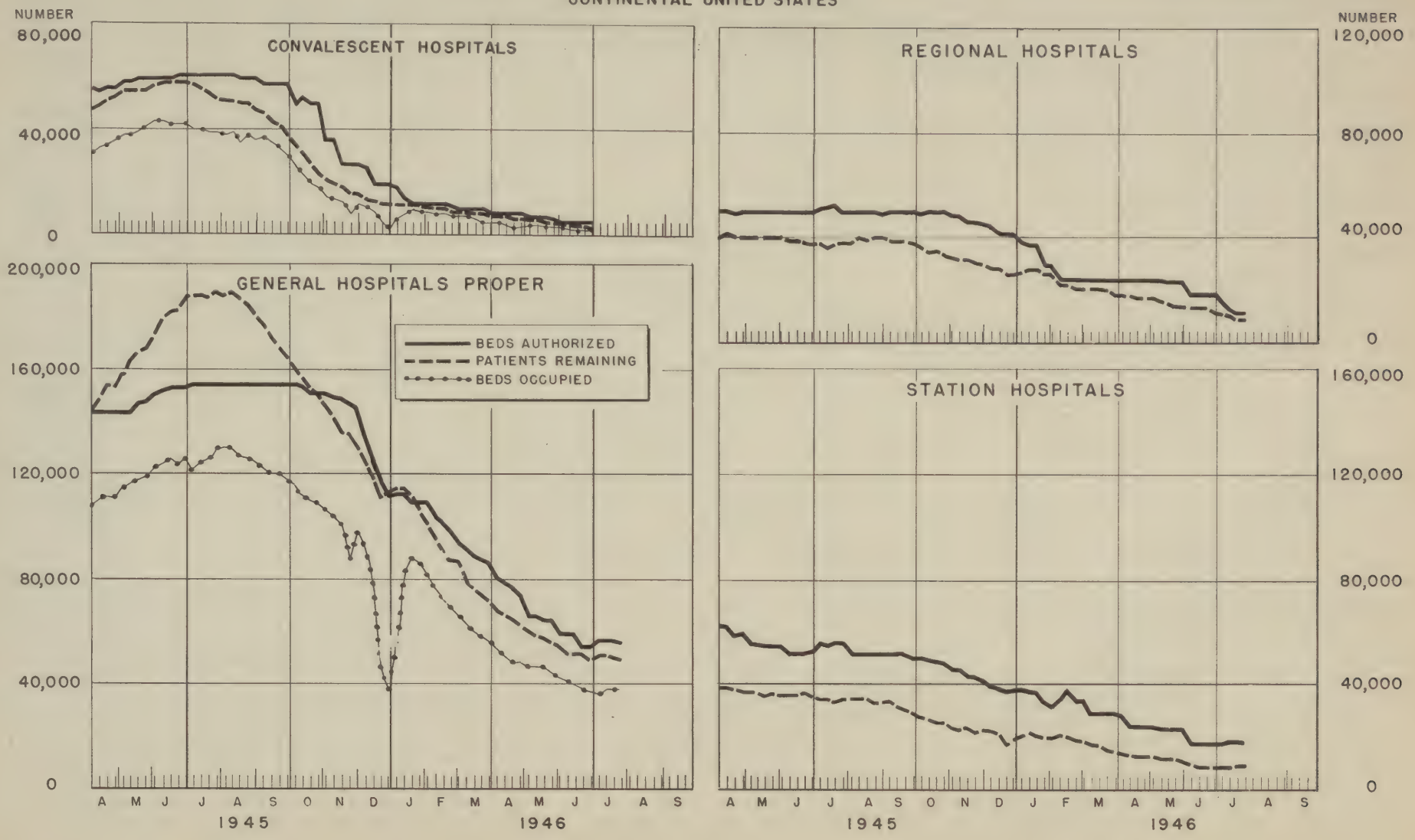
MEDICAL STATISTICS DIVISION, HEALTH REPORTS BRANCH

HOSPITALIZATION DATA BY TYPE OF HOSPITAL

CONTINENTAL UNITED STATES



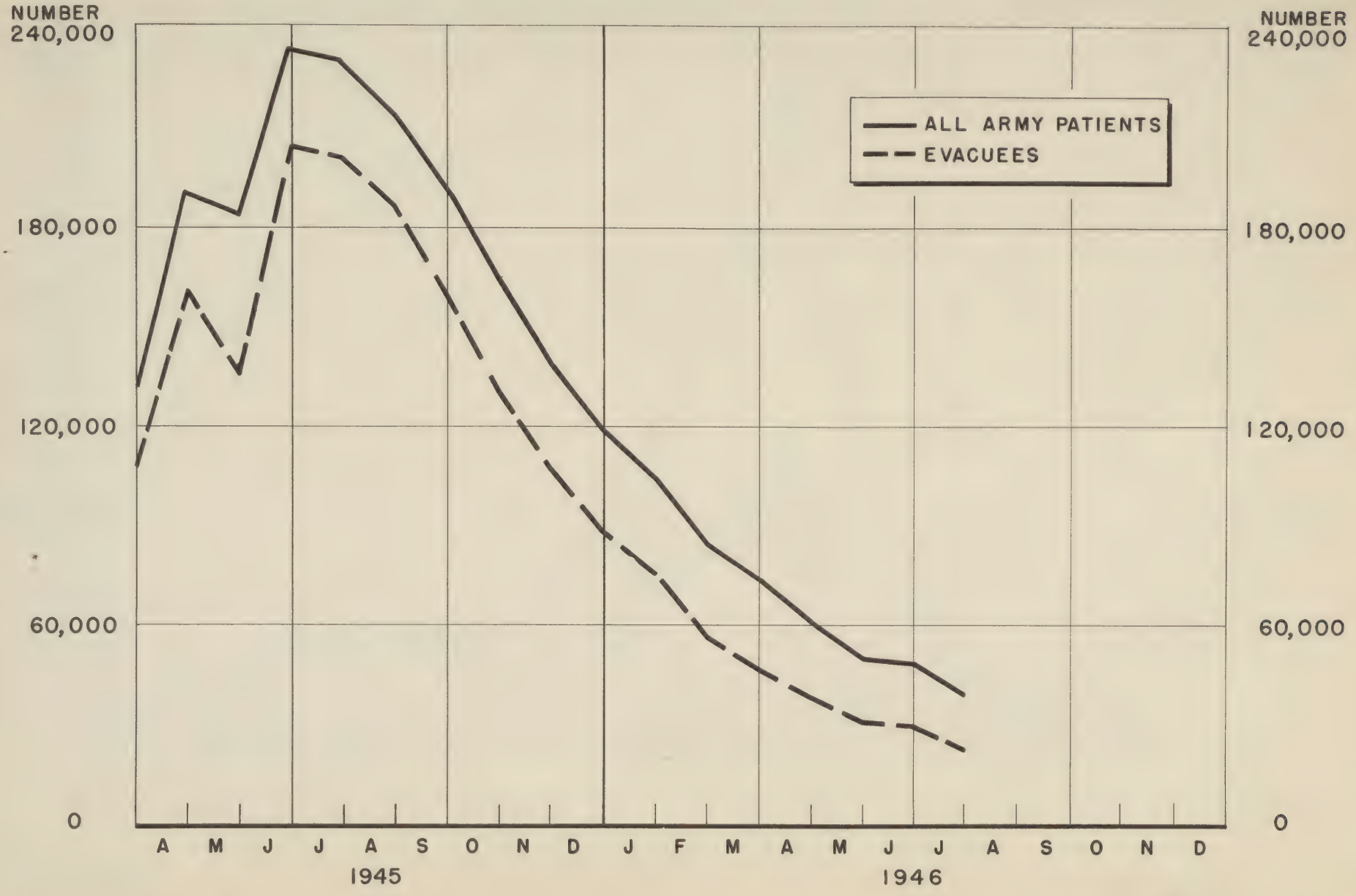
RESTRICTED

OFFICE OF THE SURGEON GENERAL
MEDICAL STATISTICS DIVISION, HEALTH REPORTS BRANCH

Enclosure No. 3

NUMBER OF EVACUEES REMAINING

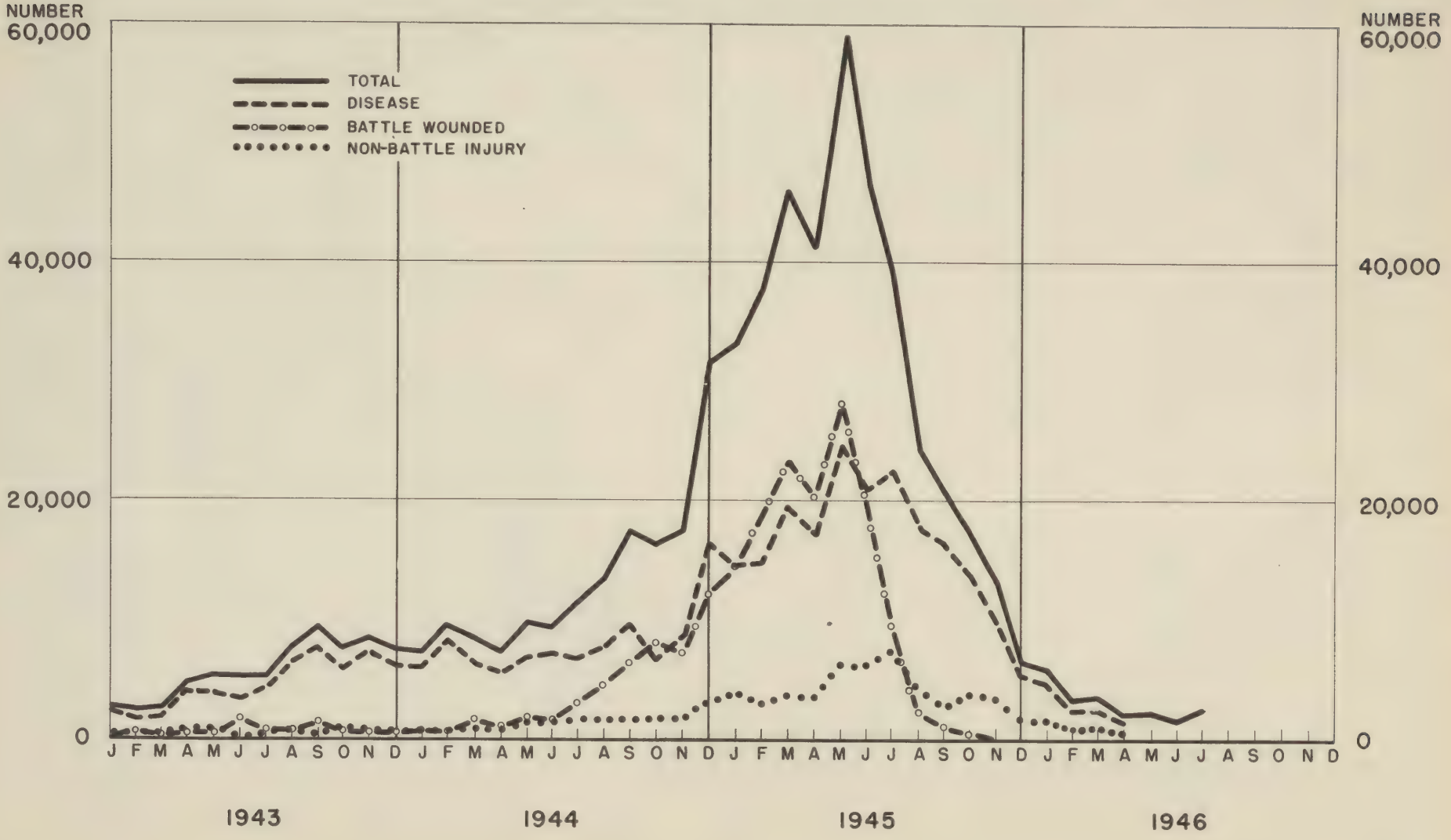
GENERAL AND CONVALESCENT HOSPITALS—END OF MONTH



ARMY PATIENTS EVACUATED TO THE UNITED STATES

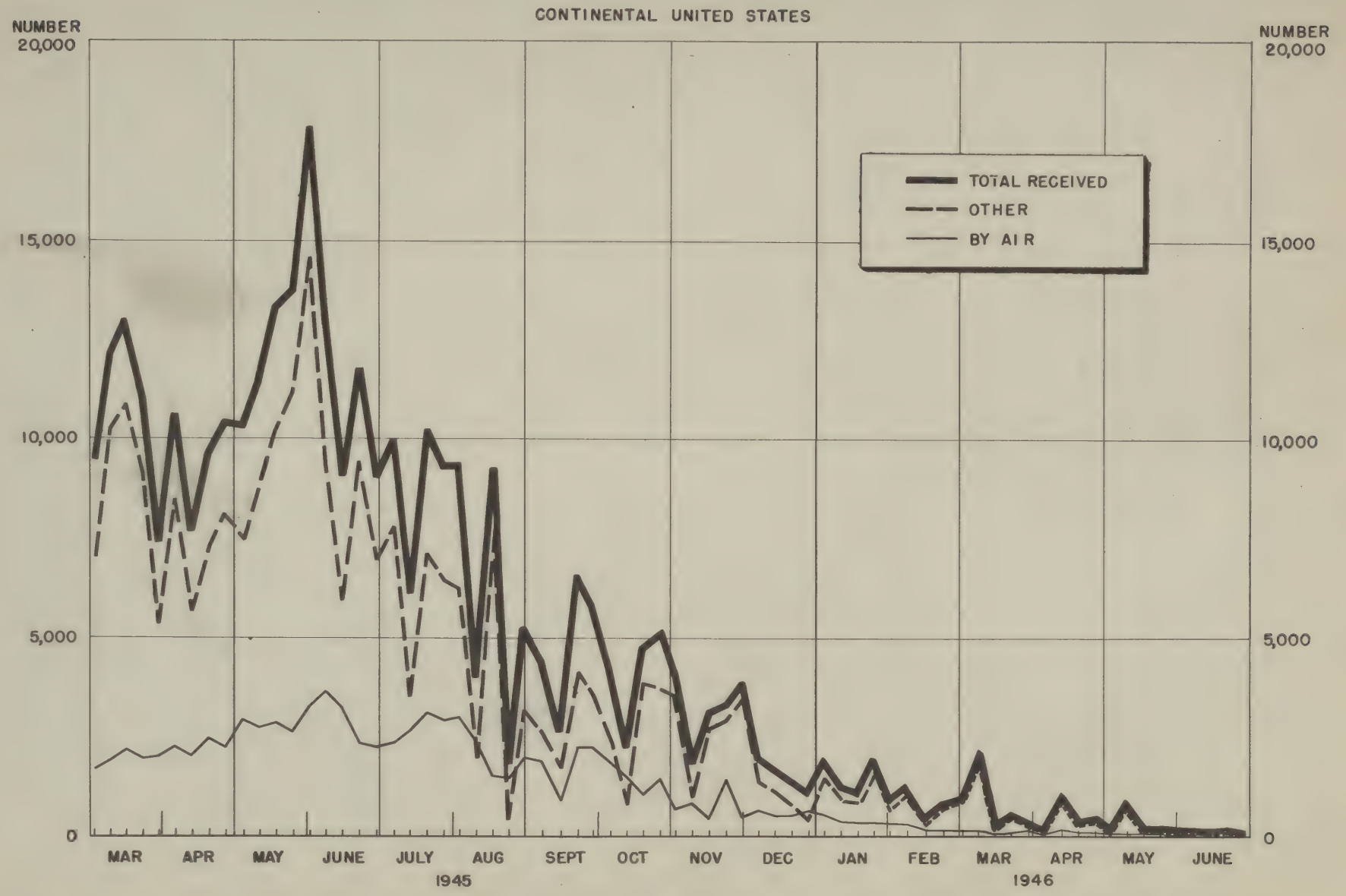
NUMBER OF PATIENTS ARRIVING EACH MONTH

EVACUATED FOR DISEASE, NON-BATTLE INJURY, AND BATTLE WOUNDED



OFFICE OF THE SURGEON GENERAL
MEDICAL STATISTICS DIVISION, HEALTH REPORTS BRANCH

DEBARKATION PATIENTS RECEIVED



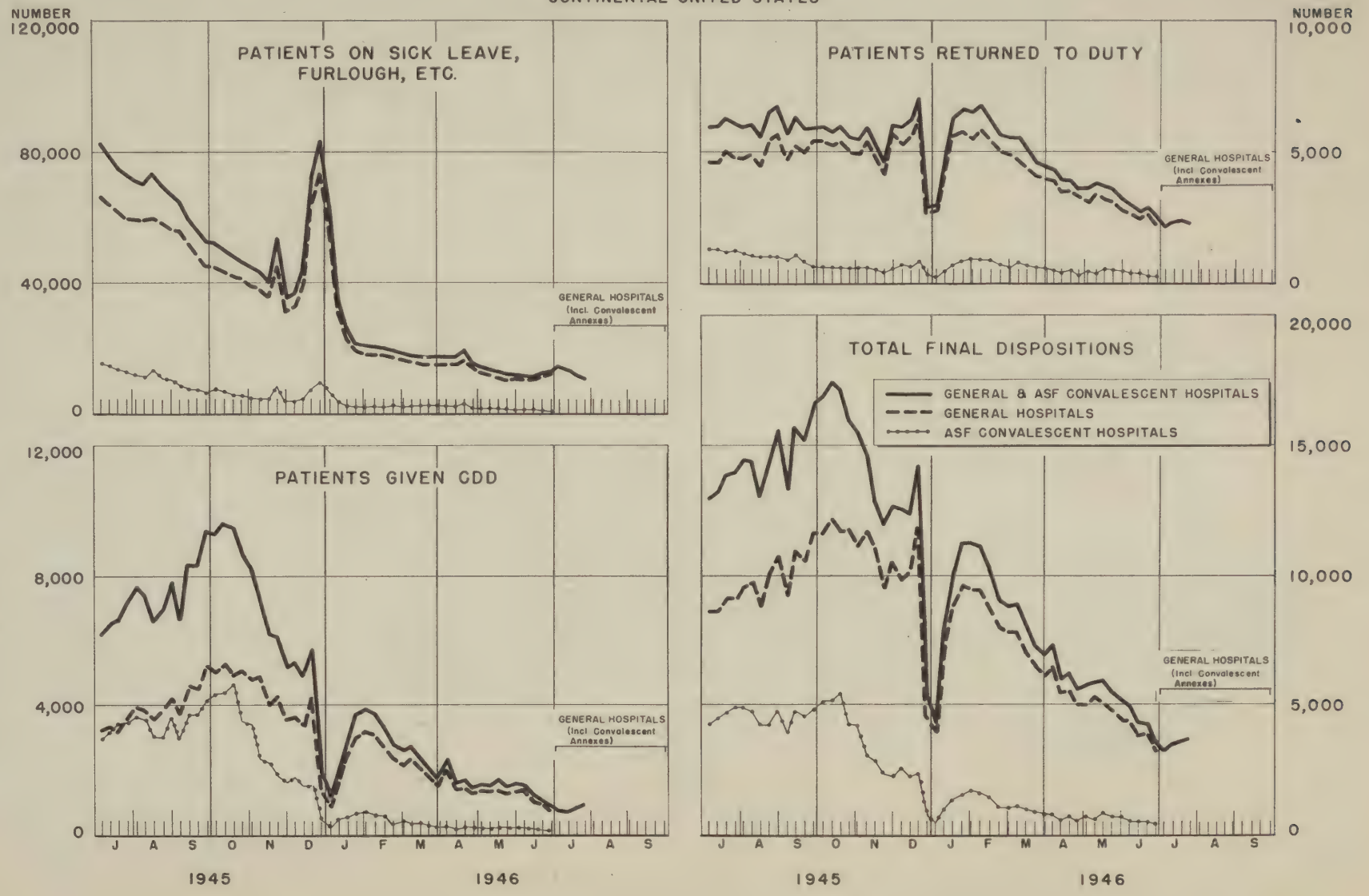
OFFICE OF THE SURGEON GENERAL
MEDICAL STATISTICS DIVISION, HEALTH REPORTS BRANCH

Enclosure No. 6

HOSPITALIZATION DATA

GENERAL AND ASF CONVALESCENT HOSPITALS

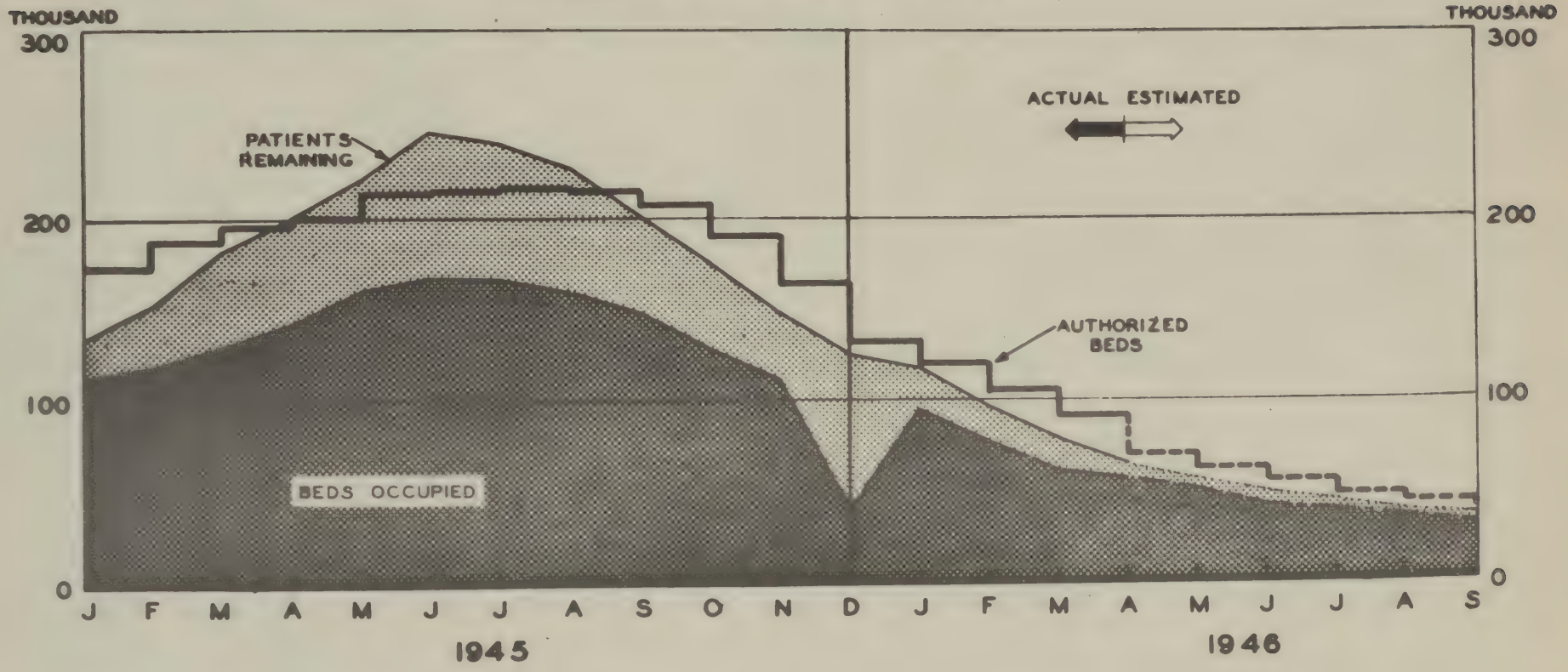
CONTINENTAL UNITED STATES



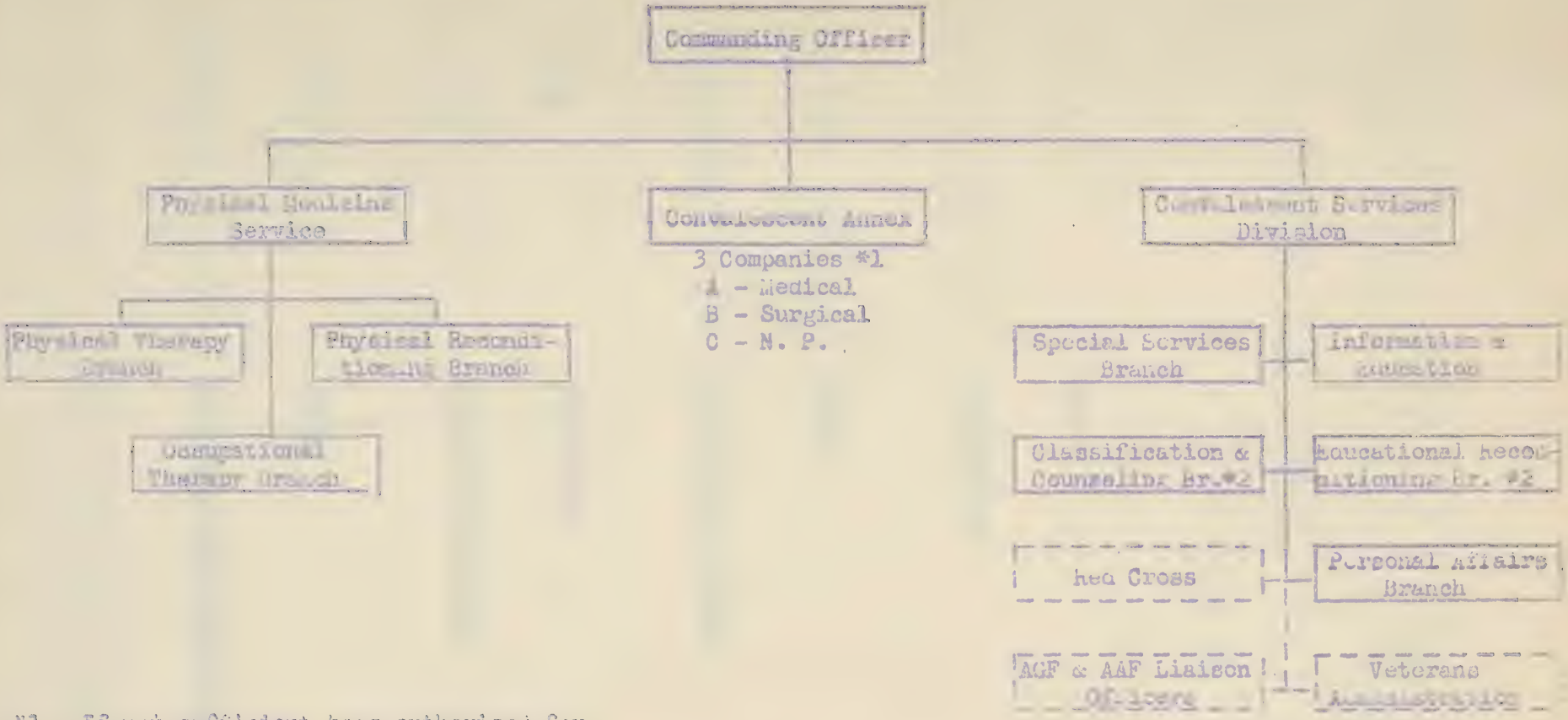
OFFICE OF THE SURGEON GENERAL
MEDICAL STATISTICS DIVISION, HEALTH REPORTS BRANCH

Enclosure No. 7

HOSPITAL CAPACITY AND PATIENT LOAD IN THE GENERAL - CONVALESCENT HOSPITAL SYSTEM IN THE UNITED STATES



NAMED GENERAL HOSPITAL
ESTABLISHMENT OF PHYSICAL MEDICINE SERVICE AND CONVALESCENT SERVICES DIVISION



*1 - If not sufficient beds authorized for 3 companies, 2 or one company may be organized for administration with platoons for 3 professional specialties.

*2 - To be absorbed by Education Officer, I&E Branch, in the future.

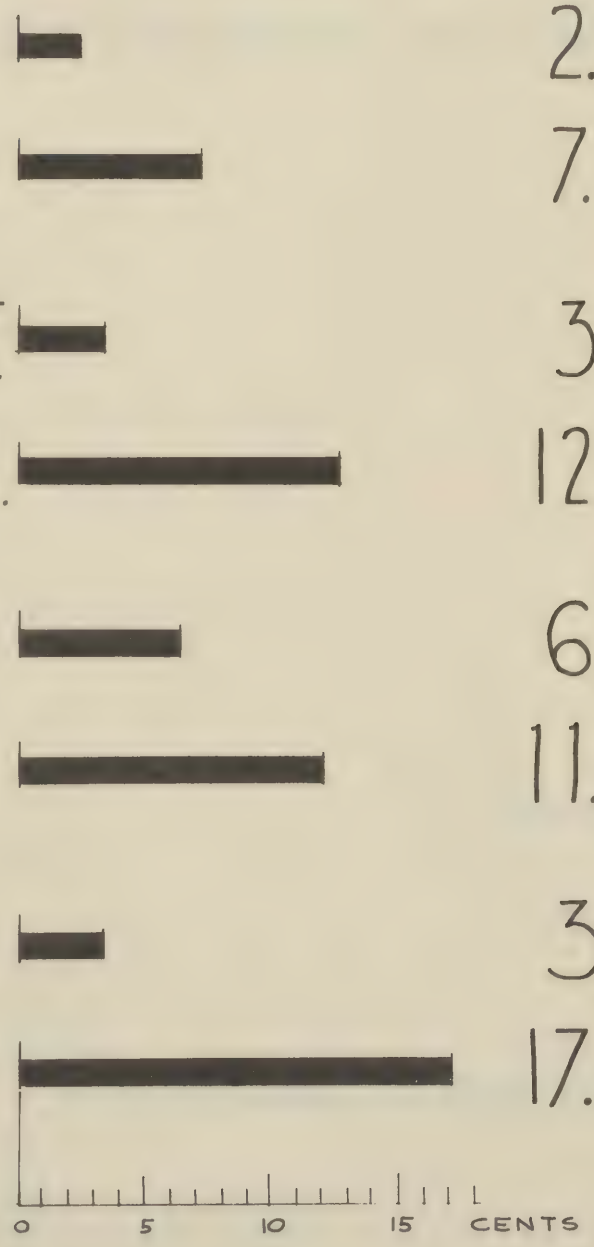
(_ _ _ _ _ _ Indicates Liaison)

20 August 1945

Lieutenant Col. P.

BUILDING · MAINTENANCE · COSTS ·

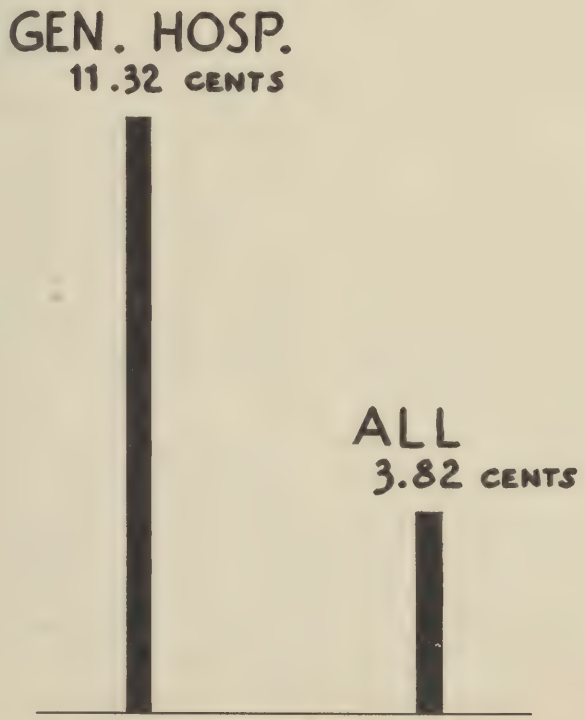
AVERAGE PER SQ. FT.
F.Y. 1946



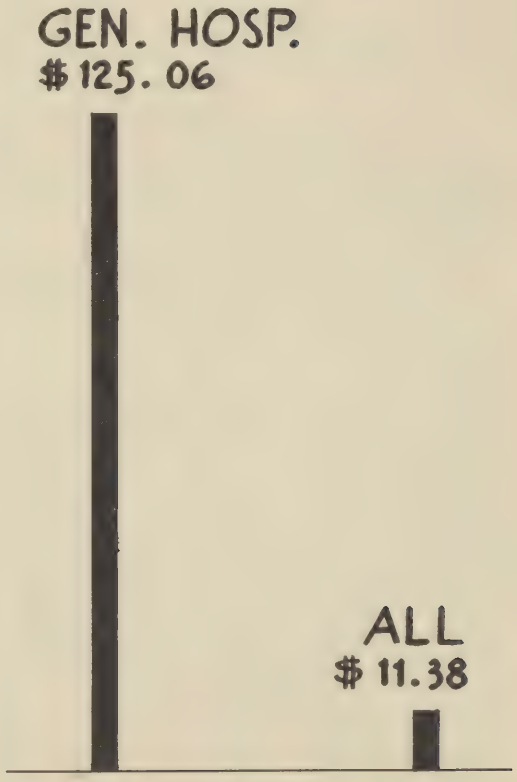
COMPARATIVE MAINTENANCE COSTS

AVERAGE OF ALL CLASS I AND CLASS II INSTALLATIONS · COMPARED WITH GENERAL HOSPITALS

F.Y. 1946



BUILDINGS PER SQ. FT.



IMPROVED GROUNDS PER ACRE

OFFICE OF THE CHIEF OF ENGINEERS
REPAIRS & UTILITIES DIVISION
MAINTENANCE & REPAIR BRANCH
BUILDING & STRUCTURES SECTION

STATUS OF RESIDENCIES

[P] PERMANENT APPROVAL
[T] TEMPORARY APPROVAL
[R] COUNCIL REC'MD TO AMERICAN BOARDS

NOTIFY FOLLOWING RE CHANGES
1. CHIEF, EDUCATION AND TRAINING DIVISION (a) Chief, Officer Branch
2. CHIEF, CLASSIFICATION, MILITARY PERSONNEL DIVISION

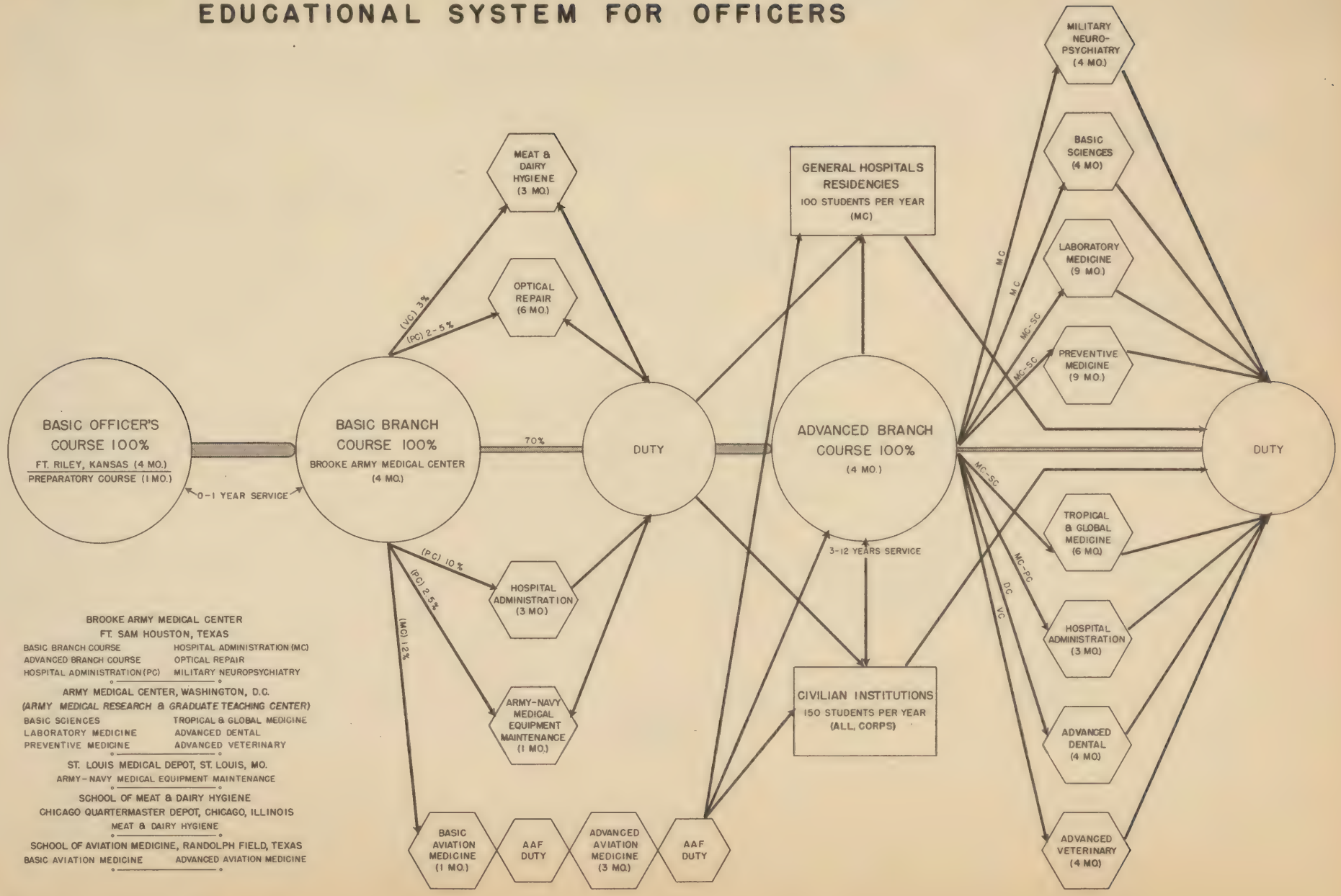
RESIDENCIES / HOSPITAL	ANESTHESIOLOGY	CARDIOLOGY	DERMATOLOGY AND SYPHILOLOGY	MEDICINE	MIXED RESIDENCY	NEUROPSYCHIATRY	NEUROSURGERY	OBSTETRICS AND GYNECOLOGY	OPHTHALMOLOGY AND OTOLARYNGOLOGY	ORTHOPEDIC SURGERY	PATHOLOGY	PEDIATRICS	PHYSICAL THERAPY	PLASTIC SURGERY	RADIOLOGY	SURGERY	THORACIC SURGERY	TUBERCULOSIS	UROLOGY	INTERN-SHIP
*ARMY MEDICAL CENTER											R									
ARMY AND NAVY															T					
BROOKE		R	R	R	P			R		T	R	R			T	P			R	P
FITZSIMONS				P	P	R				T	P	R			P	P	P	T		P
LETTERMAN					P					T		R			T					P
MADIGAN					P					T					P					P
OLIVER	R		R	R	P	R				R					R					P
PERCY JONES	R			R	P	R				R	R				R					P
WALTER REED	R	R	R	R	P	R	R	R	R	R	R	R	P		R	R	R		R	P
Wm BEAUMONT	R			R	P	R				T						P			R	P

* ARMY INSTITUTE OF PATHOLOGY

25-96153

U. S. ARMY MEDICAL DEPARTMENT

EDUCATIONAL SYSTEM FOR OFFICERS



BROOKE ARMY MEDICAL CENTER
FT. SAM HOUSTON, TEXAS

BASIC BRANCH COURSE	HOSPITAL ADMINISTRATION (MC)
ADVANCED BRANCH COURSE	OPTICAL REPAIR
HOSPITAL ADMINISTRATION (PC)	MILITARY NEUROPSYCHIATRY

ARMY MEDICAL CENTER, WASHINGTON, D.C.
(ARMY MEDICAL RESEARCH & GRADUATE TEACHING CENTER)

BASIC SCIENCES	TROPICAL & GLOBAL MEDICINE
LABORATORY MEDICINE	ADVANCED DENTAL
PREVENTIVE MEDICINE	ADVANCED VETERINARY

ST. LOUIS MEDICAL DEPOT, ST. LOUIS, MO.
ARMY-NAVY MEDICAL EQUIPMENT MAINTENANCE

SCHOOL OF MEAT & DAIRY HYGIENE
CHICAGO QUARTERMASTER DEPOT, CHICAGO, ILLINOIS
MEAT & DAIRY HYGIENE

SCHOOL OF AVIATION MEDICINE, RANDOLPH FIELD, TEXAS

BASIC AVIATION MEDICINE	ADVANCED AVIATION MEDICINE

Inclosure No. 13.

AGENDA

CONFERENCE OF THE SURGEON GENERAL

with

Commanders of Named General Hospitals
22-23 August 1946

TIME AND PLACE	TOPIC FOR DISCUSSION - ACTIVITY	DISCUSSION CHAIRMAN
22 August 1946 - Room 2E 408, The Pentagon		
0830 - 0900	Register in Executive Office Room 2E-284, The Pentagon	
0900 - 0915	Welcoming Address	Maj. Gen.N.T.Kirk
0915 - 0930	Statement of Conference Aims	Brig. Gen.R.W.Bliss
0930 - 1030	Army Hospitalization Program: Review of Hospitalization Program, including present and Projected Status of General Hospital Operation, Class II Hospitals at Class I Posts, and Future Plans	Lt. Col.J.T.McGibony
1030 - 1100	Long Range Hospital Construction Program, including activities of Post Planning Boards	Lt. Col.J.Souder
1100 - 1115	Recess	
1115 - 1145	Maintenance,Repair and Utilities in Army Hospitals	Representative,Ofc.C Engrs.
1145 - 1215	Open Discussion	Lt.Col.J.T.McGibony and Conferees

Incl. #14

22 August 1946 - Room 2E-408 (Cont'd)

1215 - 1400	Luncheon - Officers' Dining Room Lounge Corridor 10, 3rd Floor, between A and C Rings	
1400 - 1500	Army Hospitalization Program (Cont'd) The Federal Hospitalization Program, including Bureau of Budget Interests in Army Hospitalization Program	Representative, Bureau of Budget
1500 - 1630	Army Hospital Supply Program: Methods of Handling Supply of Non-standard items; Establishment of Allowances and Control of Issue of Equipment Hospital Equipment Modernization Program	Col. S.B. Hays
1900 -	Reception and Dinner (Officers) - Officers' Club, Army Medical Center	

A G E N D A

CONFERENCE OF THE SURGEON GENERAL

with

Commanders of Named General Hospitals
22-23 August 1946

TIME AND PLACE	TOPIC FOR DISCUSSION - ACTIVITY	DISCUSSION CHAIRMAN
23 August 1946 - Room 2E-408, The Pentagon		
0900 - 1130	Personnel Problems in Army Hospitals:	Col.F.P.Kintz
(0930 - 1045)	Use of Medical Department Specialists and Expert Consultants General Discussion of Personnel Problems, including Central Officer's Assignment Group; Army Integration and Army Interne Programs; Officer and Enlisted Personnel; Nursing, Dietetic and Physical Therapy Personnel; Civilian Personnel	Col.A.Freer and Col.F.L.Cole Col.F.P.Kintz, Officers & Civilians
(1045 - 1100)	Recess	
(1100 - 1115)	Dental Personnel	Brig. Gen. T.L.Smith
(1115 - 1130)	Performance of Station Complement Functions at Class II Hospitals	Major R.Murray,Jr.
1130 - 1200	Fiscal Problems in Army Hospitals, Including availability of Funds and Proper Charges against Appropriated Funds.	Mr. N. Fogelberg

23 August 1946 - Room 2E - 408 (Cont'd)

1200 - 1315	Lunch - Officers' Dining Room - Lounge Corridor 10, 3rd Floor, Between A and C Rings	
1315 - 1415	Training Activities at Army Hospitals: Professional Graduate Training Program, including Interim Refresher Training, Interne Training, and Residency Training Programs Training of General Reserve Units	Col.R.E.Duke
1415 - 1500	Professional Administrative Problems in Army Hospitals, including Board Procedures in connection with the Disposition of Patients	Col.A.N.Nylen
1500 - 1520	Preventive Medicine Problems in Army Hospitals	Col.T.F.Whayne
1520 - 1630	General Discussion and Summary	Maj.Gen.N.T.Kirk, Brig.Gen.R.W.Bliss, Brig.Gen.G.B.Denit and Hospital Commanders